Supreme Court, U. S.
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MICHAEL RODAK, JR., CLERK

APPENDIX

IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1691

Paul I. Guest, et al.,
Appellants,

v.

F. Emmett Fitzpatrick, Jr., et al.,
Appellees.

No. 75-1698

Williamsport Hospital, et al.,
Appellants,

v.

F. Emmett Fitzpatrick, Jr., et al.,
Appellees.

Appeals from the United States District Court for the Eastern District of Pennsylvania

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No. 75-1691, Filed May 21, 1976
No. 75-1698, Filed May 24, 1976
Probable Jurisdiction Noted October 4, 1976

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C. Financial Statement of Doylestown Hospital as at June 30, 1974..... (omitted)

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G. Financial Statement of Paoli Memorial Hospital as at June 30, 1975..... (omitted)

H. Financial Statement of Delaware County Memorial Hospital as at June 30, 1974..... (omitted)

I. Correspondence and Memorandum re Mercy Catholic Medical Center Medicare Cost Audit..... (omitted)

J. Financial Statement of Presbyterian-University of Pennsylvania Medical Center as at June 30, 1975..... (omitted)

K. Memorandum and Letter from Cost Manager of Presbyterian-University of Pennsylvania Medical Center..... (omitted)

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RELEVANT DOCKET ENTRIES

	1975		
1	Aug. 11		Complaint, filed.
1	Aug. 11		Summons exit.
2	Aug. 14		Deft. Blue Cross of Greater Phila's notice of deposition of Plff., filed.
3	Aug. 25		Appearance of Bonnie Brigance Leadbetter, Asst. District Attorney, for Deft. F. Emmett Fitzpatrick, filed.
4	Aug. 27		Appearance of Howard M. Holmes, Asst. Attorney General, for Deft. Robert P. Kane, filed.
5	Sept.	3	Report of Pretrial Conference, Weiner, J., filed.
6	Sept.	3	Answer of Deft. F. Emmett Fitzpatrick, filed.
—	Sept.	3	CASE LISTED FOR TRIAL
7	Sept.	12	Plffs' Motion to add Defts.; Motion of Williamsport Hospital, et al, to Intervene as Plffs.; Memorandum in support thereof; and Certificate of Service, filed.
7	Sept.	25	Order dtd 9/19/75 that the Insurance Dept. of the Commonwealth of Pa. be made party Deft., etc.; that Williamsport Hospital, Delaware Valley Hospital Council, and Hospital Association of Penna. have leave to INTERVENE, etc., filed. 9/26/75 entered and copies mailed. CW
	Sept.	25	Amended Complaint, filed.
8	Sept.	25	Stipulation and Order dtd 9/19/75 WITHDRAWING request for temporary restraining order, without prejudice; counsel for Deft. Fitzpatrick is excused from participa-

tion in any hearings & arguments, etc.; extending time to 10/2/75 for Defts. to answer, etc.; that parties anticipate convening Three-Judge Court, and fixing hearing and argument on cross-Motions for Summary Judgment for 10/14/75, etc., filed.
CW

9 Oct. 3 Order dtd 9/30/75 designating VanDusen, J., U.S. Circuit Judge, and Luongo, J., to sit with Weiner, J., as members of the Court for hearing and determination of this matter, filed.
10/7/75 entered and copies mailed.
(including Gov. and Attorney Gen.)
Seitz, Ch.J.

10 Oct. 7 Answer of Defts. Blue Cross of Greater Phila., Robert P. Kane, and Insurance Dept. of the Commonwealth of Pa. to Amended Complaint, filed.

11 Oct. 7 Plffs. and Plffs-Intervenors' Motion for Summary Judgment, Memorandum in support thereof, and Certificate of Service, filed.

12 Oct. 7 Joint Motion of Defts. Blue Cross of Greater Phila., Robert Kane, and Insurance Dept. of Commonwealth of Pa., for Summary Judgment, and Brief in support thereof, filed.

13-16 Oct 7 Affidavit of Bruce Taylor, President, Blue Cross of Greater Phila., with accompanying exhibits), filed. (4 Vols.)

17 Oct. 14 Supplemental Affidavit of Bruce Taylor, President, Blue Cross of Greater Phila., with accompanying exhibits, filed.

— Oct. 14 Argued sur Cross-Motions for Summary Judgment, C.A.V.
CW

18 Oct. 29 Supplemental Affidavits of Paul I. Guest and Joseph A. Williamson with attachments, filed.

19 Nov. 17 Supplemental Memorandum & Affidavits of Bruce Taylor & Jerome Lynch, with Accompanying Exhibits, filed.

1976

20 Feb. 27 Opinion, Van Dusen, C.J., and Weiner, J.; Dissenting Opinion, Luongo, J.; and Order that Plffs' motion for Summary Judgment is DENIED; Defts' motions for Summary Judgment are GRANTED, filed.
3/2/76 entered and copies mailed.
(incl. Gov. & Att. General)
VanDusen
CW & AL

21 Mar. 22 Notice of Appeal of Plffs., filed.
3/23/76 entered and copies mailed. USCA, counsel, Gov. & Att.

22 Mar. 22 Copy of Clerk's Notice to U.S. Court of Appeals, filed
3/23/76 entered and copy to VanDusen, C. J., Luongo, J., and Weiner, J.

23 Mar. 22 Plffs' Notice of Appeal to the Supreme Court of the United States, filed.

24 Mar. 26 Plffs. Williamsport Hospital and the Hospital Association of Penna.'s Notice of Appeal to the Supreme Court of the United States, filed.

— Apr. 13 Record on appeal transmitted to U.S. Court of Appeals.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No.

PAUL I. GUEST, President of Methodist Hospital; CHARLES H. FRENZEL, Executive Vice President of Mercy Catholic Medical Center; PHILIP J. SAWLINSKY, Manager of Patient Accounts of ST. JOSEPH's HOSPITAL; and METHODIST HOSPITAL, on behalf of themselves and all others similarly situated,

Plaintiffs

v.

EMMETT F. FITZPATRICK, JR., District Attorney of Philadelphia, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, Individually and in their Official Capacities, and BLUE CROSS of GREATER PHILADELPHIA,

Defendants

COMPLAINT—CLASS ACTION

Parties

1. Plaintiff Paul I. Guest, is the president of plaintiff Methodist Hospital, located at 2301 South Broad Street, Philadelphia, Pennsylvania, 19148; plaintiff, Charles H. Frenzel is the executive vice president of Mercy Catholic Medical Center which includes its Misericordia Hospital Division located at 54th Street and Cedar Avenue, Philadelphia, Pennsylvania 19143; plaintiff Philip J. Sawlinsky is the manager of patient accounts at St. Joseph's Hospital located at 16th Street and Girard Avenue, Philadelphia, Pennsylvania 19130; and plaintiff Methodist Hospital is a non-profit corporation organized under the laws of Pennsylvania and located at 2301 South Broad Street,

Philadelphia, Pennsylvania, 19148. All hospitals which are members of the plaintiff class herein are eligible hospitals within the meaning of Section 6121 of Title 40 of the Pennsylvania Consolidated Statutes, 40 Pa. C.S. § 6121, and all executive officers, administrators and employees who are members of the plaintiff class are attached to such hospitals. Together the hospitals in the class have more than 5% of the beds in an area served by defendant Blue Cross of Greater Philadelphia, a hospital plan corporation within the meaning of § 6102 of that Title 40.

2. Defendant Emmett F. Fitzpatrick, Jr. ("Fitzpatrick") is the District Attorney of Philadelphia, Pennsylvania. Defendant Robert P. Kane ("Kane") is Attorney General of the Commonwealth of Pennsylvania. Each has responsibility for the enforcement of Act No. 94, ("the Act"), Act of August 2, 1975, amending § 6124 of Title 40 of the Pennsylvania Consolidated Statutes, which provides, *inter alia,* a procedure whereby the termination of all existing and future contracts, as well as certain terminated contracts, between eligible hospitals and hospital plan corporations are to be subject to ninety days notice and to prior approval by the Insurance Department which is authorized to suspend termination of such contracts for a period of almost ten additional months pending its approval. They are sued individually and in their official capacities. Defendant Blue Cross of Greater Philadelphia ("Blue Cross") is a non-profit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with its principal office and place of business at 1333 Chestnut Street, Philadelphia, Pennsylvania 19107. Defendant Blue Cross is an insurance company whose primary business is the sale of health care insurance to individuals and groups in Southeastern Pennsylvania. As such, it is a hospital plan corporation within the meaning of 40 Pa. C.S. § 6102.

Nature of Action

3. This is an action for a declaratory judgment and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202. The action arises from an actual controversy between plaintiffs and defendants as hereinafter fully appears. Plaintiffs seek a declaration that the retroactive application of the Act to a now terminated contract previously in force between plaintiff hospital and hospitals in the class and defendant Blue Cross is repugnant to the Constitution of the United States, specifically the Contract Clause, Article I, Section 1, Clause 10, and the Due Process Clause of the Fourteenth Amendment. An injunction against defendants Fitzpatrick and Kane is sought to prevent enforcement of the Act by means of the criminal penalties provided at Section 6105 of Title 40 of the Pennsylvania Consolidated Statutes, which, by its terms, would expose all plaintiffs and other members of the class of hospitals and hospital executive officers, administrators and employees which they seek to represent, to criminal penalties upon any violation of the Act. A further injunction is sought against defendant Blue Cross to prevent enforcement of the terminated contract.

Jurisdiction

4. This Court has jurisdiction over this matter under 28 U.S.C. § 1331 since the action arises under the Constitution of the United States as set forth above in paragraph 3 of this Complaint and the amount in controversy exceeds the sum of Ten Thousand Dollars ($10,000) exclusive of interest and costs, and under 28 U.S.C. §1343(3) because the action arises under the Constitution of the United States, specifically the Due Process Clause of the Fourteenth Amendment and the Contract Clause.

5. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 since

plaintiffs seek an injunction to restrain the enforcement, operation and execution of a statute of the Commonwealth of Pennsylvania, which has statewide application, on the grounds that said statute is violative of the United States' Constitution.

Operative Facts

6. The Act, entitled "An Act Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, adding provisions relating to contractual relationships between hospital plan corporations and hospitals, providing for the maintenance of such contractual relationship during disputes, authorizing the Insurance Department to take certain action with respect thereto, and providing for the temporary restoration of certain lapsed contractual relationships," amends Section 6124 of Title 40 by the addition of a subsection (c) which provides that ". . . termination of contracts between hospital plan corporations [here defendant Blue Cross] and hospitals entered into pursuant to Section 6121 (relating to eligible hospitals) and this Section to be subject to prior approval by the department as provided in this subsection."

A procedure is thereafter prescribed at subparagraphs (2), (3) and (4) whereby ninety days notice of termination is required and the Insurance Department is empowered to suspend the termination of such contracts, provided the hospitals involved have more than 5% of the beds in an area served by a hospital plan corporation, for a period of almost ten months thereafter, during which time the parties are to continue to be bound by all terms and conditions of the contract sought to be terminated.

7. Section 2 of the Act provides that the above procedure shall apply not only prospectively to the termination of future covered contracts but also retroactively to "any contracts between hospital plan corporations and

hospitals under which subscribers received prepaid benefits on or after June 30, 1974, if such hospital plan corporations and hospitals were governed by contracts subject to 40 Pa. C.S. Chap. 61 (relating to Hospital Plan Corporations) or corresponding provisions of law on June 30, 1964 and substantially continuously thereafter to and including June 30, 1974. *Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.*" (Emphasis supplied).

Section 3 of the Act expressly provides that "[t]his act shall take effect immediately and *shall be retroactive to the extent provided in Section 2 hereof.*" (Emphasis supplied).

8. The Delaware Valley Hospital Council, on behalf of plaintiff hospital and others of the class which it represents, and defendant Blue Cross adopted a contract, approved by the Insurance Department in accordance with 40 Pa. C.S. § 6124, under which defendant Blue Cross as insurer paid plaintiff hospital and others in its class ("provider hospitals") an agreed portion but less than all of the hospitals' actual cost of providing treatment for Blue Cross subscribers. This contract, as modified and extended by a "Summary of Principles to be Utilized in Drafting an Interim 1973 Hospital Agreement" (which 1973 Agreement was never successfully negotiated), terminated by its terms on June 30, 1974, and, subject to certain "run out" provisions providing for the orderly termination of coverage to individual subscribers,* defend-

* Pursuant to a Settlement Agreement reached in *Crozer Chester Medical Center, et al.* v. *Blue Cross of Greater Philadelphia,* No. 9799, 1974 Term (C.P. Del. Co. September 25, 1974), the "run out" provisions of the original contract as modified by the Summary of Principles went into effect on August 15, 1974. During this "run out" period, subscribers' coverages have terminated, each on its anniversary date, so that all coverage for all subscribers will have ceased as of August 15, 1975 but for the application of Act No. 94.

ant Blue Cross ceased to pay the hospitals directly pursuant to the terminated contract, but the patient-subscribers gradually became billable directly by the hospitals for the *full* costs of their hospitalization and treatment, just as are nonsubscriber private paying patients.

Class Action Allegations

9. The present action is brought by the named plaintiffs on their own behalf and as representatives of a class, as defined in Rule 23 of the Federal Rules of Civil Procedure, comprised of all hospitals which were signatories to the Summary of Principles with defendant Blue Cross, which contract had lawfully terminated as of June 30, 1974, and which contract is now reinstated by the express provisions of the Act, and all executives, administrators, and employees of those hospitals responsible for the billing of patients, directly or indirectly, all of whom are liable to criminal prosecution under Section 6105 of Title 40 of the Pennsylvania Consolidated Statutes in the event of a failure to comply with the terms of the reinstated contract in accordance with the provisions of the Act. The members of the class are, likewise, directly involved in the application of the reinstated contract between defendant Blue Cross and plaintiff hospital class. The members of the class are so numerous as to make it impracticable to bring them before the Court. The questions of law and fact common to the class predominate over any question affecting individual members only. The claims of the representative plaintiffs are typical—if not identical—to the claims of the sub-class represented by each, and plaintiffs will fairly and adequately protect the interests of the class.

10. The prosecution of separate actions by individual members of the class would create the risk of:

(a) inconsistent or varying adjudications with respect to individual members of the class; and

(b) adjudications with respect to individual members of the class which would, as a practical matter, be dispositive of the interests of the members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

COUNT I

(All Defendants)

11. Paragraphs 1 through 10 of this Complaint are incorporated herein by reference.

12. Under the express provisions of Section 2(2) of the Act, the contract between defendant Blue Cross and plaintiff hospital class, terminated over a year ago, is reinstated as of its original termination date and, under the provisions of Section 1 of the Act, may not now be terminated without ninety days notice and without the consent of the Insurance Department for a period of up to ten months thereafter, all from the effective date of the Act.

13. The effect of the application of the Act to the above contract would be to destroy the plaintiff hospitals' legal right to full payment for services rendered Blue Cross subscribers, a right previously modified by agreement and restored, pending compliance with the "run out" provisions, when the contract embodying that agreement terminated on June 30, 1974. Thus, for the elapsed one year period since the "run out" provisions went into effect and for up to thirteen months hence, the hospitals in plaintiff class will be required to accept partial payment for services for which they are entitled to full payment.

14. Under the terms of the contract imposed upon the plaintiff hospital class by governmental action, the hospitals cannot recover their legitimate costs of supplying services and facilities to Blue Cross subscribers for the period from the time the contract lawfully terminated through the time that termination is to be deemed finally effective. This constitutes a governmental taking of property without just compensation condemned by the Due Process Clause. *Louisville Joint Stock Land Bank* v. *Radford,* 295 U.S. 555 (1935); *Fornaris* v. *Ridge Tool Co.,* 423 F.2d 563 (1st Cir.), *rev'd on other grounds* 400 U.S. 41 (1970). Even with respect to public utilities, a state legislature has no power to impose contracts requiring the provision of service at confiscatory rates, like those imposed here, which do not permit a recovery of costs. *Prendergast* v. *New York Telephone Co.,* 262 U.S. 43 (1923).

15. Retroactive application of the Act to reinstate a contract already terminated without protection of the substantial rights thereby affected, constitutes an impairment of contract prohibited by the Contract Clause. This is true regardless of the alleged public interest involved. *W.B. Worthen Co.* v. *Kavanagh,* 295 U.S. 56 (1935). *See Superior Motors, Inc.* v. *Winnebago Inds., Inc.,* 259 F. Supp. 773 (D.S.C. 1973).

16. Accordingly, both the Due Process and Contract Clauses prohibit retroactive application of the Act to a contract which had been lawfully terminated prior to its passage, where the effect of such application would be to impose upon plaintiff hospitals a contractual obligation which would not otherwise exist, to render service at a confiscatory rate which will not permit them to recover the legitimate costs of providing that service.

COUNT II

(Defendants Fitzpatrick and Kane)

17. Paragraphs 1 through 16 of this Complaint are incorporated herein by reference.

18. Section 6105 of Title 40 prescribes criminal penalties against any person or legal entity violating any provision of that Chapter or any regulations or orders of the Insurance Department made pursuant thereto, which Section is applicable to provisions of the Act amending 40 Pa. C.S. § 6124.

19. Having determined that the Act is unconstitutional for the reasons set forth above at paragraphs 13 through 16 of this Complaint, members of plaintiff class are now confronted with an insoluable trilemma: they are barred by the Act, upon pain of criminal prosecution under § 6105, from attempting to recover their costs, *inter alia,* by direct billing of patient-subscribers; they cannot bill defendant Blue Cross for the portion of their costs recoverable under the contract without risk of being estopped from pressing their constitutional challenge to the Act, *see, e.g., Wall* v. *Parrott Silver & Copper Co.,* 244 U.S. 407 (1917); and they are clearly not in a financial position simply to absorb the costs associated with treating Blue Cross subscribers—who constitute more than a third of the patient population of plaintiff hospitals—without billing either defendant Blue Cross or its subscribers pending the determination of this suit.

20. Unless plaintiffs are granted injunctive relief against enforcement of the Act pending resolution of this action, they will suffer irreparable injury, being forced either to sacrifice a substantial constitutional challenge to the Act which, under applicable law, is almost certain to prevail upon the merits, or to expose themselves to criminal penalties in order to preserve their constitutional challenge.

21. Unless plaintiffs are granted injunctive relief the public will suffer irreparable injury since non-profit hospitals cannot be forced to provide service to one-third

of their patients at confiscatory rates without adversely affecting their service to the general public from whom their patient population is drawn.

22. The granting of a preliminary injunction will in no way harm defendants or the public, since it will do no more than preserve the status quo as it existed prior to passage of the challenged legislation and require that those receiving service from plaintiff hospitals—including Blue Cross subscribers—must be responsible for the hospitals' legitimate costs of rendering these services.

COUNT III

(Defendant Blue Cross)

23. Paragraphs 1 through 16 of this Complaint are incorporated herein by reference.

24. On August 5, 1975, defendant Blue Cross, without consulting with the Insurance Department of the Commonwealth of Pennsylvania or with representatives of plaintiff hospital class, sent out a letter to the chief executive officers of the hospitals represented by Delaware Valley Hospital Council ("DVHC") announcing that defendant Blue Cross would hereafter make payments under the terminated contract reinstated by Act No. 94. That letter stated that "[b]y your acceptance of these payments, you will be deemed to have agreed with us that such represent full payment for these cases . . . notwithstanding any subsequent decision as to the applicability or constitutionality of Act No. 94 to the Agreement or these cases." The letter further provided that each check would contain a restrictive endorsement incorporating this "understanding." A copy of the letter is attached hereto as Exhibit A.

25. On August 8, 1975, representatives of defendant Blue Cross and of plaintiff hospital class, including plain-

tiff Guest, met under the auspices of the Commissioner of the Insurance Department of the Commonwealth of Pennsylvania to discuss the orderly implementation of Act No. 94 and the way in which its constitutionality could be challenged in the least disruptive manner. The representatives of defendant Blue Cross refused to participate in the meeting and walked out of it.

26. On August 11, 1975, defendant Blue Cross without consulting with DVHC or its member hospitals whose names were listed on the advertisement, caused a full page advertisement to be placed in the Philadelphia Inquirer which announced that "your Blue Cross card will be accepted by all member hospitals [of DVHC] as of August 2, 1975." The advertisement further stated that subscribers who were billed by hospitals represented by DVHC during the period after the termination of the agreement between member hospitals and defendant Blue Cross are no longer liable for the full costs of their treatment and that those who paid that full cost should receive refunds from the hospitals. A copy of the advertisement is attached hereto as Exhibit B.

27. Paragraph 19 of this Complaint is incorporated herein by reference.

28. By means of the procedure outlined in the letter of August 5, 1975, defendant Blue Cross has sought to prevent plaintiff hospital class from recovering the full costs of services provided by these hospitals even if Act No. 94 is determined to be unconstitutional. By refusing to negotiate in the presence of the Insurance Commissioner and by placing its advertisement in the August 11, 1975 Philadelphia Inquirer, defendant Blue Cross has sought to force plaintiff hospital class to accept Act No. 94 whether or not it is constitutional, and has sought to prevent the development of an orderly procedure for

testing the constitutionality of that Act without requiring that the members of plaintiff hospital class accept less than full compensation for services provided Blue Cross subscribers even if the Act is determined to be unconstitutional.

29. Unless plaintiffs are granted injunctive relief against enforcement of the Act pending resolution of this action, they will suffer irreparable injury, being forced either to sacrifice the benefits of a substantial constitutional challenge to the Act which, under applicable law, is almost certain to prevail upon the merits, or to receive no payments from defendant Blue Cross for services rendered to Blue Cross subscribers during the period in which they litigate this challenge.

30. Paragraph 21 of this Complaint is incorporated herein by reference.

31. The granting of a preliminary injunction will in no way harm defendant Blue Cross or the public, since it will do no more than preserve the status quo as it existed prior to passage of the challenged legislation and require that those receiving service from plaintiff hospitals—including Blue Cross subscribers—must be responsible for the hospitals' legitimate cost of rendering those services.

WHEREFORE, plaintiffs pray that this Court:

(1) issue an order temporarily restraining defendants Fitzpatrick and Kane from enforcing the criminal penalties for violating Act No. 94;

(2) issue an order temporarily restraining defendant Blue Cross from requiring plaintiff hospital class to waive the benefits of a determination that Act No. 94 is unconstitutional;

(3) issue an order convening a three-judge district court as required by 28 U.S.C. §§ 2281 and 2284;

(4) advance this action on the docket and order a speedy hearing of this action according to law, and upon such hearing enter an order;

(a) declaring Act No. 94 unconstitutional as applied retroactively to reinstate a contract terminated before passage of the Act and to impose upon hospitals in plaintiff class a duty to provide services at a confiscatory rate of payment;

(b) enjoining preliminary pending final resolution of this action, and permanently thereafter, enforcement and application of the Act insofar as it impairs plaintiff hospitals' legal right to recover the full cost of hospitalization and services rendered by them to patients; and

(c) granting such other and further relief as may be appropriate in the circumstances.

/s/ JAMES D. CRAWFORD

FRANK H. ABBOTT
JAMES D. CRAWFORD
SUSAN L. CARROLL
Attorneys for Plaintiff

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102

Of Counsel

Dated: August 11, 1975

EXHIBIT A

BLUE CROSS OF GREATER PHILADELPHIA

August 5, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE DVHC REPRESENTED HOSPITALS

Dear Sir:

On August 2, 1975, Governor Shapp signed into law Act No. 94 which requires that contractual relationships between hospitals and non-profit hospital plan corporations may only be terminated pursuant to that legislation. Accordingly, since the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement"), has not been so terminated, we will immediately move to take such administrative action as is necessary and appropriate in light of the reinstatement of the Agreement.

In that regard, it is requested that you immediately file your fiscal 1975-1976 budgets on the approved forms as required by Section 18 of the Agreement. Upon receipt of this information we will undertake the budgetary review process and thereafter establish, as appropriate, revised inpatient interim per diem rates. Furthermore, we are reviewing all Blue Cross cases which were previously paid on a non-member indemnity basis directly to Subscribers. At such time as this process has been completed, we will promulgate the administrative procedures we propose to follow in making any required retroactive payment, including restoration of the advances contemplated by the 1973 Summary of Principles.

Commencing immediately Blue Cross will make daily payments to all hospitals pursuant to the Agreement for Covered Services rendered Subscribers on a current basis.

These payments shall be based on the present interim inpatient per diem rates, which amounts will be adjusted when the budgetary information requested above has been received and approved. By your acceptance of these payments, you will be deemed to have agreed with us that such represent full payment for these cases, both inpatient and outpatient, subject only to the adjustments required by the Agreement, notwithstanding any subsequent decision as to the applicability or constitutionality of Act No. 94 to the Agreement or these cases. Moreover, each check representing such payment shall contain a restrictive endorsement indicating that such is made pursuant to this understanding and represents your full concurrence thereto. This policy is being adopted to eliminate any question as to the obligation of Blue Cross to make duplicate payments to the Provider and Subscriber for the same Covered Services.

The teletype confirmations which Blue Cross provides hospitals in response to inquires as to a given Subscriber's benefits shall, for the remainder of this month, indicate by the addition of a double asterisk (**) after their name those individuals who would have been entitled to member benefits without Act No. 94. This identification procedure is intended to quickly identify such cases for your continuing records.

If after reviewing the foregoing you have any question as to the methodology or procedure that Blue Cross intends to follow, please feel free to contact our offices.

Very truly yours,

/s/ Howard W. Baker, M.D.

Howard W. Baker, M.D.
Vice President

HWB: ccb

EXHIBIT B

(Copy of advertisement in August 11, 1975, edition of The Philadelphia Inquirer, placed by Blue Cross of Greater Philadelphia—omitted)

(Affidavit omitted in printing)

(Title omitted in printing)

ORDER FOR HEARINGS ON PRELIMINARY INJUNCTION AND TEMPORARY RESTRAINING ORDER

And Now, this day of August, 1975, upon presentation and consideration of plaintiffs' verified Complaint requesting a preliminary injunction,

It Is Hereby Ordered that plaintiffs' Motion for a Preliminary Injunction be, and the same hereby is, set for hearing before a Three-Judge district court on the day of , 1975, at M. in Room in the United States District Court for the Eastern District of Pennsylvania and that a copy of this Order be served immediately, together with a copy of the summons and complaint, upon the defendants and due return be made according to law.

And It Is Further Ordered that, since defendants are about to commit the acts sought to be preliminarily enjoined and immediate and irreparable harm will thereby result to plaintiffs before hearing can be held on a preliminary injunction, immediate hearing will be held on the attached temporary restraining orders.

J.

(Title omitted in printing)

TEMPORARY RESTRAINING ORDER
(Defendants Fitzpatrick and Kane)

This matter having come on to be heard upon plaintiffs' motion for a temporary restraining order, supported by a verified Complaint, and it appearing to the Court that plaintiffs and the class they represent and the general public will suffer immediate and irreparable harm if before their motion for preliminary injunction can be heard, they are forced either to risk criminal penalties by attempting to recover the full costs of providing service to Blue Cross subscribers, or to waive their constitutional challenge to Act 94 by claiming partial payment under the contract imposed upon them by the Act, or to defer any attempt to recover these costs and risk insolvency before their claims are finally resolved; and counsel for defendants Fitzpatrick and Kane having been given notice of this application and opportunity to state why it should not be granted; and it further appearing that none of the defendants nor the public will suffer immediate and irreparable harm as a result of the issuance of a temporary restraining order designed to preserve the status quo pending the hearing on plaintiffs' motion for a preliminary injunction;

It Is Ordered that defendants Fitzpatrick and Kane, the officers, servants and employees and all other persons in active concert or participation with them be, and they are hereby, temporarily restrained from enforcing against plaintiffs the penal provisions contained at Section 6105 of Title 40 of the Pennsylvania Consolidated Statutes.

It Is Further Ordered that the foregoing order shall expire on , 1975, unless it is further ex-

tended by order of the Court or unless defendants Fitzpatrick and Kane consent that it may be extended for a longer period.

It Is Further Ordered that plaintiffs file their bond, with corporate surety, in the sum of , conditioned for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined.

_____

J.

(Title omitted in printing)

TEMPORARY RESTRAINING ORDER
(Defendant Blue Cross)

This matter having come on to be heard upon plaintiffs' motion for a temporary restraining order, supported by a verified Complaint, and it appearing to the Court that plaintiffs and the class they represent and the general public will suffer immediate and irreparable harm if before their motion for preliminary injunction can be heard, they are compelled by unilateral action of defendant Blue Cross to accept payment in accordance with the terms of the contract "reinstated" by Act No. 94 on condition that they waive any right to full compensation for services rendered Blue Cross subscribers, even if Act No. 94 is determined to be unconstitutional; and counsel for defendant Blue Cross having been given notice of this application and opportunity to state why it should not be granted; and it further appearing that none of the defendants nor the public will suffer immediate and irreparable harm as a result of the issuanuce of a temporary re-

straining order designed to preserve the status quo pending the hearing on plaintiffs' motion for a preliminary injunction;

IT IS ORDERED that defendant Blue Cross, its officers, servants and employees and all other persons in active concert or participation with it be, and they are hereby, temporarily restrained from unilaterally requiring plaintiffs to accept payment in accordance with the terms of the contract "reinstated" by Act No. 94 on condition that they waive any right to full payment for services rendered Blue Cross subscribers even if Act No. 94 is held to be unconstitutional.

IT IS FURTHER ORDERED that the foregoing order shall expire on , 1975, unless it is further extended by order of the Court or unless defendant Blue Cross consents that it may be extended for a longer period.

IT IS FURTHER ORDERED that plaintiffs file their bond, with corporate surety, in the sum of , conditioned for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined.

J.

(Certificate of service omitted in printing)

(title omitted in printing)

STIPULATION

It is hereby stipulated between plaintiffs, by their counsel James D. Crawford, and defendant F. Emmett Fitzpatrick, Jr., by his counsel Bonnie Brigance Leadbetter, defendant Robert P. Kane, by his counsel Howard Holmes, and defendant Blue Cross of Greater Philadelphia, by its counsel Denis Brenan, with the approval of the Court, that:

1. In the light of the agreement of defendants Fitzpatrick and Kane, by their counsel, not to seek criminal sanctions for acts committed by members of the class represented by plaintiffs which might be in violation of Act No. 94 while that Act remains subject to constitutional challenge, the request for a temporary restraining order against defendants Fitzpatrick and Kane is withdrawn without prejudice;

2. In the light of the exchange of correspondence between Howard W. Baker, M.D., Vice President of Blue Cross of Greater Phiadelphia, and the Chief Executive Officers of DVHC represented hospitals on August 5, 20, 21 and 26, between Frank H. Abbott, counsel for the DVHC represented hospitals, and William Zeiter, counsel for Blue Cross of Greater Philadelphia, on August 21, 1975, and Mr. Zeiter's reply on August 22 and the letter of Mr. Abbott to Mr. Taylor on August 27, 1975 and Mr. Taylor's reply of the same date, the request for a temporary restraining order against defendant Blue Cross is hereby withdrawn without prejudice;

3. Counsel for defendant Fitzpatrick is excused from participation in any hearings or arguments in this case for the reasons set forth in the answer of defendant F. Emmett Fitzpatrick but will be served copies of all papers filed in the case and will receive notice of all hearings and arguments therein;

4. If plaintiffs or others represented by counsel for plaintiffs wish to file an amended complaint or a motion to intervene as plaintiffs, the amended complaint or motion to intervene will be filed on or before September 10, 1975;

5. The time within which defendants must answer, move or otherwise plead to the original complaint in this case or to any amended complaint or motion to intervene is extended to October 2, 1975;

6. Plaintiffs, including any additional plaintiffs, and defendants Kane and Blue Cross will prepare cross motions for summary judgment with supporting affidavits and memoranda in support thereof and will file and serve the motions, affidavits and memoranda upon the Court and parties on or before October 2, 1975; and

7. The parties anticipate that a three-judge court will be convened, there being no opposition to this request on behalf of defendants, and that a hearing and argument on the cross motions for summary judgment will be scheduled before that Court on October 13, 1975 or such other time as the Court finds appropriate.

/s/ JAMES D. CRAWFORD

JAMES D. CRAWFORD
FRANK H. ABBOTT
SCHNADER, HARRISON, SEGAL & LEWIS

Counsel for Plaintiffs
Paul I. Guest, President of Methodist Hospital; Charles H. Frenzel, Executive Vice President of Mercy Catholic Medical Center; Philip J. Sawlinsky, Manager of Patient Accounts of St. Joseph's Hospital; and Methodist Hospital

/s/ BONNIE BRIGANCE LEADBETTER

BONNIE BRIGANCE LEADBETTER
Assistant District Attorney

Counsel for Defendant
F. Emmett Fitzpatrick, Jr.
District Attorney of Philadelphia

/s/ HOWARD HOLMES

HOWARD HOLMES
Assistant Attorney General

Counsel for Defendant
Robert P. Kane, Attorney General of the Commonwealth of Pennsylvania

/s/ DENIS BRENAN

DENIS BRENAN

Counsel for Defendant
Blue Cross of Greater Philadelphia

The foregoing stipulation is approved by the Court this 19th day of September, 1975.

/s/ CHARLES R. WEINER

J.

(title omitted in printing)

AMENDED COMPLAINT,
MOTION TO INTERVENE AS PLAINTIFFS,
MOTION BY PLAINTIFFS TO ADD DEFENDANT,
MEMORANDUM OF LAW,
ORDER, AND
CERTIFICATE OF SERVICE

AMENDED COMPLAINT—CLASS ACTION

Parties

1. Plaintiff Paul I. Guest, is the president of plaintiff Methodist Hospital, located at 2301 South Broad Street, Philadelphia, Pennsylvania, 19148; plaintiff, Charles H. Frenzel is the executive vice president of Mercy Catholic Medical Center which includes its Misericordia Hospital Division located at 54th Street and Cedar Avenue, Philadelphia, Pennsylvania 19143; plaintiff Philip J. Sawlinsky is the manager of patient accounts at St. Joseph's Hospital located at 16th Street and Girard Avenue, Philadelphia, Pennsylvania 19130; and plaintiff Methodist Hospital is a non-profit corporation organized under the laws of Pennsylvania and located at 2301 South Broad Street, Philadelphia, Pennsylvania, 19148. Plaintiff-intervenor Williamsport Hospital is a non-profit corporation organized under the laws of Pennsylvania and located at 777 Rural Avenue, Williamsport, Pennsylvania, 17701; plaintiff-intervenor Delaware Valley Hospital Council ("DVHC") is a non-profit corporation organized under the laws of Pennsylvania and located at 311 South Juniper Street, Philadelphia, Pennsylvania, 19107; and plaintiff-intervenor Hospital Assocation of Pennsylvania ("HAP") is a non-profit corporation organized under the laws of Pennsylvania and located at

1200 Camp Hill Bypass, Camp Hill, Pennsylvania, 17011. All hospitals which are members of the plaintiff class herein are eligible hospitals within the meaning of Section 6121 of Title 40 of the Pennsylvania Consolidated Statutes, 40 Pa. C.S. § 6121, and all executive officers, administrators and employees who are members of the plaintiff class are attached to such hospitals. DVHC and HAP are organizations whose members are also members of the plaintiff hospital class within their respective geographic areas. Together the hospitals in the class located in the Delaware Valley have more than 5% of the beds in an area served by defendant Blue Cross of Greater Philadelphia, a hospital plan corporation within the meaning of § 6102 of that Title 40, and the hospitals on the class located in Northeastern Pennsylvania have more than 5% of the beds in the area served by Hospital Services Association of Northeastern Pennsylvania, a hospital plan corporation within the meaning of § 6102 of that Title 40.

2. Defendant F. Emmett Fitzpatrick ("Fitzpatrick") is the District Attorney of Philadelphia, Pennsylvania. Defendant Robert P. Kane ("Kane") is Attorney General of the Commonwealth of Pennsylvania. Defendant the Insurance Department of Pennsylvania ("Insurance Department") is a department of the Commonwealth of Pennsylvania established by the Act of May 17, 1921, P.L. 789, § 201, 40 P.S. § 41. Each has responsibility for the enforcement of Act No. 94, ("the Act"), Act of August 2, 1975, amending § 6124 of Title 40 of the Pennsylvania Consolidated Statutes, which provides, *inter alia,* a procedure whereby the termination of all existing and future contracts, as well as certain terminated contracts, between eligible hospitals and hospital plan corporations are to be subject to ninety days notice and to prior approval by defendant Insurance Department which is authorized to

suspend termination of such contracts for a period of almost ten additional months pending its approval. Defendants Fitzpatrick and Kane are sued individually and in their official capacities. Defendant Blue Cross of Greater Philadelphia ("Blue Cross') is a non-profit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with its principal office and place of business at 1333 Chestnut Street, Philadelphia, Pennsylvania 19107. Defendant Blue Cross is an insurance company whose primary business is the sale of health care insurance to individuals and groups in Southeastern Pennsylvania. As such, it is a hospital plan corporation within the meaning of 40 Pa. C.S. § 6102.

Nature of Action

3. This is an action for a declaratory judgment and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202. The action arises from an actual controversy between plaintiffs and plaintiffs-intervenors ("plaintiffs") on the one hand and defendants on the other as hereinafter fully appears. Plaintiffs seek a declaration that the application of the Act to contracts between plaintiff hospitals and hospitals in the class and various hospital plan corporations including defendant Blue Cross is repugnant to the Constitution of the United States, specifically the Contract Clause, Article I, Section 1, Clause 10, and the Due Process Clause of the Fourteenth Amendment. An injunction against defendants Fitzpatrick and Kane is sought to prevent enforcement of the Act by means of the criminal penalties provided at Section 6105 of Title 40 of the Pennsylvania Consolidated Statutes, which, by its terms, would expose all plaintiffs and other members of the class of hospitals and hospital executive officers, administrators and employees which they seek to represent, to criminal penalties upon any violation of the Act. An

injunction against defendant Insurance Department is sought to prevent administrative execution and enforcement of the Act. A further injunction is sought against defendant Blue Cross to prevent enforcement of the terminated contract.

Jurisdiction

4. This Court has jurisdiction over this matter under 28 U.S.C. § 1331 since the action arises under the Constitution of the United States as set forth above in paragraph 3 of this Complaint and the amount in controversy exceeds the sum of Ten Thousand Dollars ($10,000) exclusive of interest and costs, and under 28 U.S.C. § 1343(3) because the action arises under the Constitution of the United States, specifically the Due Process Clause of the Fourteenth Amendment and the Contract Clause.

5. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 since plaintiffs seek an injunction to restrain the enforcement, operation and execution of a statute of the Commonwealth of Pennsylvania, which has statewide application, on the grounds that said statute is violative of the United States Constitution.

Operative Facts

6. The Act, entitled "An Act Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, adding provisions relating to contractual relationships between hospital plan corporations and hospitals, providing for the maintenance of such contractual relationship during disputes, authorizing defendant Insurance Department to take certain action with respect thereto, and providing for the temporary restoration of certain lapsed contractual relationships," amends Section 6124 of Title

40 by the addition of a subsection (c) which provides that ". . . termination of contracts between hospital plan corporations [here including defendant Blue Cross] and hospitals entered into pursuant to Section 6121 (relating to eligible hospitals) and this Section to be subject to prior approval by the Insurance Department as provided in this subsection."

A procedure is thereafter prescribed at subparagraphs (2), (3) and (4) whereby ninety days notice of termination is required and additional defendant Insurance Department is empowered to suspend the termination of such contracts, provided the hospitals involved have more than 5% of the beds in an area served by a hospital plan corporation, for a period of almost ten months thereafter, during which time the parties are to continue to be bound by all terms and conditions of the contract sought to be terminated.

7. Section 2 of the Act provides that the above procedure shall apply not only prospectively to the termination of covered contracts entered into in the future but also retroactively to both existing contracts and to "any contracts between hospital plan corporations and hospitals under which subscribers received prepaid benefits on or after June 30, 1974, if such hospital plan corporations and hospitals were governed by contracts subject to 40 Pa. C.S. Chap. 61 (relating to Hospital Plan Corporations) or corresponding provisions of law on June 30, 1964 and substantially continuously thereafter to and including June 30, 1974. Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this Act."

Section 3 of the Act expressly provides that "[t]his act shall take effect immediately and shall be retroactive to the extent provided in Section 2 hereof."

8. Plaintiff-intervenor DVHC, on behalf of plaintiff Methodist Hospital and others of the class which it represents in the Delaware Valley, and defendant Blue Cross adopted a contract, approved by defendant Insurance Department in accordance with 40 Pa. C.S. § 6124, under which defendant Blue Cross as insurer paid the Delaware Valley members of the hospital class ("provider hospitals") an agreed portion but less than all of the hospitals' actual cost of providing treatment for Blue Cross subscribers. This contract, as modified and extended by a "Summary of Principles to be Utilized in Drafting . . . [a never successfully negotiated] Interim 1973 Hospital Agreement," (together "Delaware Valley Agreement") terminated by its terms on March 31, 1974, and, subject to certain "run out" provisions providing for the orderly termination of coverage to individual subscribers,* defendant Blue Cross ceased to pay the hospitals directly pursuant to the terminated contract, but the patient-subscribers gradually became billable directly by the hospitals for the *full* costs of their hospitalization and treatment, just as are non-subscriber private paying patients. Plaintiff-intervenor Williamsport Hospital and others of the class which it represents in Northeastern Pennsylvania and Hospital Services Association of Northeastern Pennsylvania, a hospital plan corporation, adopted a contract ("Northeastern Pennsylvania Agreement") approved by defendant Insurance Department in accordance with 40 Pa. C.S. § 6124, under which Hospital Services Corpora-

* Pursuant to a Settlement Agreement reached in *Crozer Chester Medical Center, et al.* v. *Blue Cross of Greater Philadelphia,* No. 9799, 1974 Term (C.P. Del. Co. September 25, 1974), the "run out" provisions of the original contract as modified by the Summary of Principles went into effect on August 15, 1974. During this "run out" period, subscribers' coverages have terminated, each on its anniversary date, so that all coverage for all subscribers will have ceased as of August 15, 1975 but for the application of Act No. 94.

tion of Northeastern Pennsylvania as insurer pays the Northeastern Pennsylvania members of the hospital class an agreed portion but less than all of the hospital's actual cost of providing treatment for its subscribers, which contract remains in effect. Other hospital plan corporations throughout Pennsylvania have entered similar contracts with other members of plaintiff hospital class; some of the contracts had terminated before June 30, 1974, some since that date and some are still in effect.

Class Action Allegations

9. The present action is brought by the named plaintiffs on their own behalf and as representatives of a class, as defined in Rule 23 of the Federal Rules of Civil Procedure, comprised of all hospitals which were signatories to the Summary of Principles with defendant Blue Cross, which contract had lawfully terminated as of March 31, 1974, and which contract is now reinstated by the express provisions of the Act, and all those hospitals outside the Delaware Valley which have received payments from various hospital plan corporations so as to make them subject to the Act, and all executives, administrators, and employees of any of those hospitals responsible for the billing of patients, directly or indirectly, all of whom are liable to criminal prosecution under Section 6105 of Title 40 of the Pennsylvania Consolidated Statutes in the event of a failure to comply with the terms of the reinstated contract in accordance with the provisions of the Act. Similarly, the members of the hospital class are directly and the other members of plaintiff class are indirectly subject to the enforcement of the act by defendant Insurance Department. The members of the class within the Delaware Valley are, likewise, directly involved in the application of the contract, reinstated by the Act, between defendant Blue Cross and the Delaware Valley members

of plaintiff hospital class. The members of the class are so numerous as to make it impracticable to bring them before the Court. The questions of law and fact common to the class predominate over any question affecting individual members only. The claims of the representative plaintiffs are typical—if not identical—to the claims of the sub-class represented by each, and plaintiffs will fairly and adequately protect the interests of the class.

10. The prosecution of separate actions by individual members of the class would create the risk of:

(a) inconsistent or varying adjudications with respect to individual members of the class; and

(b) adjudications with respect to individual members of the class which would, as a practical matter, be dispositive of the interests of the members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

COUNT I

(All Parties)

11. Paragraphs 1 through 10 of this Complaint are incorporated herein by reference.

12. Under the express provisions of Section 2(2) of the Act the Delaware Valley Agreement, terminated over a year ago, is reinstated as of its original termination date and, under the provisions of Section 1 of the Act, may not now be terminated without ninety days notice and without the consent of defendant Insurance Department for a period of up to ten months thereafter, all from the effective date of the Act.

13. The effect of the retroactive application of the Act to the above-mentioned contract would be to destroy the Delaware Valley plaintiff hospitals' legal right to full pay-

ment for services rendered Blue Cross subscribers, a right previously modified by agreement and restored, pending compliance with the "run out" provisions, when the contract embodying that agreement terminated on March 31, 1974. Thus, for the elapsed one year period since the "run out" provisions went into effect and for up to thirteen months hence, the Delaware Valley hospitals in plaintiff class will be required to accept partial payment for services for which they are entitled to full payment.

14. The Northeastern Pennsylvania Agreement, the Delaware Valley Agreement and the agreements between other hospital members of plaintiff class and other hospital plan corporations contain express contract terms providing that either party may cancel the agreement on ninety days notice to the other. Under Section 1 of the Act, the termination of these agreements following the ninety days notice is extended for periods of up to six months to permit defendant Insurance Department to conduct an investigation and make findings of fact. Only after such findings are made and only with the approval of defendant Insurance Department may the contracts be terminated. Moreover, at the option of defendant Insurance Department, the parties may be required to negotiate for a period of up to ninety days before an additional thirty day termination period begins.

15. The effect of the retroactive application of the Act to both of the above-mentioned contracts would be to destroy the Delaware Valley and Northeastern Pennsylvania plaintiff hospitals' legal right to full payment for services rendered to subscriber patients under the respective agreements, a right which was always available to the hospitals involved on ninety days notice. Thus, for a period of up to ten months following the decision of such hospitals in plaintiff class to terminate the applicable agreement, those hospitals will be required to accept

partial payment for services for which they are entitled to full payment.

16. Under Pennsylvania law, regardless of the provisions of the agreement between hospital members of plaintiff class and the respective hospital plan corporations, the hospitals have always had a right to terminate their agreements upon a breach by the hospital plan corporation. Under the terms of Section 1 of the Act, this right is abrogated and the agreements may not now be terminated without ninety days notice and without the consent of defendant Insurance Department for a period of up to ten months thereafter.

17. The effect of the retroactive application of the Act to all of the above-mentioned agreements would be to destroy the plaintiff hospitals' legal right to full payment for services rendered subcribers and to require performance of the agreements by the respective hospital plan corporations, a right that had always been available to the hospital plaintiffs upon breach of the agreements by the respective hospital plan corporations. Thus, for up to thirteen months after any breach of the agreements by a hospital plan corporation, the affected hospitals in plaintiff class will be required to accept partial payment for services for which they are entitled to full payment and to forego the remedy of termination of the agreements which would otherwise be available to them upon breach by the other party.

18. Under the terms of the contract imposed upon the plaintiff hospital class by governmental action, the hospitals cannot recover their legitimate costs of supplying services and facilities to hospital plan subscribers for the period from the time the contract lawfully terminated or could lawfully be terminated through the time that termination is to be deemed finally effective. This constitutes a governmental taking of property without

just compensation condemned by the Due Process Clause. *Louisville Joint Stock Land Bank* v. *Radford,* 295 U.S. 555 (1935); *Fornaris* v. *Ridge Tool Co.,* 423 F.2d 563 (1st Cir.), *rev'd on other grounds* 400 U.S. 41 (1970). Even with respect to public utilities, a state legislature has no power to impose contracts requiring the provision of service at confiscatory rates, like those imposed here, which do not permit a recovery of costs. *Prendergast* v. *New York Telephone Co.,* 262 U.S. 43 (1923).

19. Retroactive application of the Act to reinstate a contract already terminated or to take away the parties' contractual rights to terminate existing or reinstated contracts under the terms of those contracts or under state law existing at the time of contracting without protection of the substantial rights thereby affected, constitutes an impairment of contract prohibited by the Contract Clause. This is true regardless of the alleged public interest involved. *W. B. Worthen Co.* v. *Kavanagh,* 295 U.S. 56 (1935). *See Superior Motors, Inc.* v. *Winnebago Inds., Inc.,* 259 F. Supp. 773 (D.S.C. 1973).

20. Accordingly, both the Due Process and Contract Clauses prohibit retroactive application of the Act to a contract which had been lawfully terminated prior to its passage or which contained a right of termination agreed to before the passage of the Act, where the effect of such application would be to impose upon plaintiff hospitals a contractual obligation, which would not otherwise exist, to render service at a confiscatory rate which will not permit them to recover the legitimate costs of providing that service.

COUNT II

(All Parties)

21. Paragraphs 1 through 10 of this Complaint are incorporated herein by reference.

22. In the normal course of events, all of the hospital members of the plaintiff class will enter into future agreements with one or another hospital plan corporation as defined in Chapter 61 of Title 40, Pennsylvania Consolidated Statutes, 40 Pa. C.S. §§ 6101-27. As a result of the enactment of Act No. 94, each of these contracts will be subject to the limitations on termination contained in Section 1 of that Act.

23. Paragraph 16 of this Complaint is incorporated herein by reference.

24. As a result of the enactment of Act No. 94, hospital plan corporations, which are freed from the regulations applicable to other insurance companies writing health care insurance under 40 Pa. C.S. § 6103(a), will have an unfair advantage in their negotiations with plaintiff hospitals which will deny equal protection of the laws directly to other writers of health insurance and indirectly to the hospital members of plaintiff class by the effective weakening or exclusion of insurers other than hospital plan corporations from supplying insurance to patients in the hospitals in plaintiff class and forcing patients and the hospitals in plaintiff class to deal with the hospital plan corporations.

25. Paragraphs 11 through 15 and 17 through 20 of this Complaint are incorporated herein by reference.

26. Act No. 94 contains no severability clause, and its unconstitutional retroactive effect is reason for striking down the Act in its entirety.

COUNT III

(Defendants Fitzpatrick and Kane)

27. Paragraphs 1 through 26 of this Complaint are incorporated herein by reference.

28. Section 6105 of Title 40 prescribes criminal penalties against any person or legal entity violating any provision of that Chapter or any regulations or orders of defendant Insurance Department made pursuant thereto, which section is applicable to provisions of the Act amending 40 Pa. C.S. § 6124.

29. Defendant Kane as chief law enforcement officer of the commonwealth of Pennsylvania and defendant Fitzpatrick as chief law enforcement officer of Pennsylvania's most populous county are chief among those responsible for carrying out the enforcement of the criminal provisions applicable to violations of the Act. To protect members of plaintiff class from prosecution under the unconstitutional provisions of the Act, it is necessary that defendants Kane and Fitzpatrick be enjoined from instituting such prosecutions.

30. Moreover, having determined that the Act is unconstitutional for the reasons set forth above at paragraphs 13 through 26 of this Complaint, the Delaware Valley members of plaintiff class are now confronted with an insoluable trilemma: they are barred by the Act, upon pain of criminal prosecution under § 6105, from attempting to recover their costs, *inter alia,* by direct billing of patient-subscribers; they cannot bill defendant Blue Cross for the portion of their costs recoverable under the contract without risk of being estopped from pressing their constitutional challenge to the Act, *see, e.g., Wall* v. *Parrott Silver & Copper Co.,* 244 U.S. 407 (1917); and they are clearly not in a financial position simply to absorb the costs associated with treating Blue Cross subscribers —who constitute more than a third of the patient population of plaintiff hospitals—without billing either defendant Blue Cross or its subscribers pending the determination of this suit. This same trilemma will face other members

of plaintiff class as their agreements with their respective hospital service corporations expire or as they seek to terminate these agreements.

31. Unless plaintiffs are granted injunctive relief against enforcement of the Act pending resolution of this action, they will suffer irreparable injury, being forced either to sacrifice a substantial constitutional challenge to the Act which, under applicable law, is almost certain to prevail upon the merits, or to expose themselves to criminal penalties in order to preserve their constitutional challenge.

32. Unless plaintiffs are granted injunctive relief the public will suffer irreparable injury since non-profit hospitals cannot be forced to provide service to one-third of their patients at confiscatory rates without adversely affecting their service to the general public from whom their patient population is drawn.

33. The granting of a preliminary injunction will in no way harm defendants or the public, since it will do no more than preserve the status quo as it existed prior to passage of the challenged legislation and require that those receiving service from plaintiff hospitals—including hospital plan corporation subscribers—must be responsible for the hospitals' legitimate costs of rendering these services.

COUNT IV

(Defendant Insurance Department)

34. Paragraphs 1 through 33 of this Complaint are incorporated hereby by reference.

35. Under Act No. 94, defendant Insurance Department must be given ninety days notice of every contract termination and, whenever that termination involves con-

tracts with hospitals having more than 5 percent of the beds in the area served by a hospital plan corporation, must hold public hearings and must suspend termination for up to six months to conduct an investigation, after which it must make findings of fact and either approve termination of the contract or recommend terms for its continuation. If defendant Insurance Department recommends terms for continuation, the termination of the contracts must be suspended, apparently by defendant Insurance Department, for up to ninety days. If no contract is reached during that period, the Department must approve termination of the contracts, but only to become effective after thirty days.

36. Under these provisions, defendant Insurance Department has the chief responsibility for executing and enforcing the unconstitutional provisions of Act No. 94. To protect members of plaintiff class from the execution and enforcement of these unconstitutional provisions of the Act, it is necessary that defendant Insurance Department be enjoined from executing and enforcing those provisions.

COUNT V

(Defendant Blue Cross)

37. Paragraphs 1 through 26 of this Complaint are incorporated herein by reference.

38. On August 5, 1975, defendant Blue Cross, without consulting with the Insurance Department of the Commonwealth of Pennsylvania or with representatives of plaintiff hospital class in the Delaware Valley, sent out a letter to the chief executive officers of the hospitals represented by plaintiff DVHC announcing that defendant Blue Cross would hereafter make payments under the terminated contract reinstated by Act No. 94. That letter

stated that "[b]y your acceptance of these payments, you will be deemed to have agreed with us that such represent full payment for these cases . . . notwithstanding any subsequent decision as to the applicability or constitutionality of Act No. 94 to the Agreement or these cases." The letter further provided that each check would contain a restrictive endorsement incorporating this "understanding." A copy of the letter is attached hereto as Exhibit A.

39. On August 8, 1975, representatives of defendant Blue Cross and of Delaware Valley members of plaintiff hospital class, including plaintiff Guest, met under the auspices of the Commissioner of the Insurance Department of the Commonwealth of Pennsylvania to discuss the orderly implementation of Act No. 94 and the way in which its constitutionality could be challenged in the least disruptive manner. The representatives of defendant Blue Cross refused to participate in the meeting and walked out of it.

40. On August 11, 1975, defendant Blue Cross, without consulting with plaintiff DVHC or its member hospitals whose names were listed on the advertisement, caused a full page advertisement to be placed in the Philadelphia Inquirer which announced that "your Blue Cross card will be accepted by all member hospitals [of DVHC] as of August 2, 1975." The advertisement further stated that subscribers who were billed by hospitals represented by plaintiff DVHC during the period after the termination of the agreement between member hospitals and defendant Blue Cross are no longer liable for the full cost of their treatment and that those who paid that full cost should receive refunds from the hospitals. A copy of the advertisement was attached to the original complaint as Exhibit B.

41. Paragraph 30 of this Complaint is incorporated herein by reference.

42. By means of additional correspondence between Howard W. Baker, M.D., Vice President of defendant Blue Cross, and the Chief Executive Officers of plaintiff DVHC represented hospitals on August 20, 21 and 26, between Frank H. Abbott, counsel for plaintiff DVHC represented hospitals and William Zeiter, counsel for defendant Blue Cross, on August 21, 1975, and Mr. Zeiter's reply on August 22, and the letter of Mr. Abbott to Mr. Taylor on August 27, 1975 and Mr. Taylor's reply of the same date, all of which are attached hereto as Exhibit C, defendant Blue Cross manifested its intention to continue, insofar as possible, to enforce the unilaterally adopted position originally taken in its letter attached hereto as Exhibit A.

43. By means of the procedure outlined in the letter of August 5, 1975, and reaffirmed in the subsequent correspondence defendant Blue Cross has sought to prevent Delaware Valley members of plaintiff hospital class from recovering the full cost of services provided by these hospitals even if Act No. 94 is determined to be unconstitutional. By refusing to negotiate in the presence of the Insurance Commissioner and by placing its advertisement in the August 11, 1975 Philadelphia Inquirer, defendant Blue Cross has sought to force the Delaware Valley members of plaintiff hospital class to accept Act No. 94 whether or not it is constitutional, and has sought to prevent the development of an orderly procedure for testing the constitutionality of that Act without requiring that these members of plaintiff hospital class accept less than full compensation for services provided Blue Cross subscribers even if the Act is determined to be unconstitutional.

44. Unless Delaware Valley plaintiffs are granted injunctive relief against enforcement of the Act pending resolution of this action, they will suffer irreparable

injury, being forced either to sacrifice the benefits of a substantial constitutional challenge to the Act which, under applicable law, is almost certain to prevail upon the merits, or to receive no payments from defendant Blue Cross for services rendered to Blue Cross subscribers during the period in which they litigate this challenge.

45. Paragraph 32 of this Complaint is incorporated herein by reference.

46. The granting of a preliminary injunction will in no way harm defendant Blue Cross or the public, since it will do no more than preserve the status quo as it existed prior to passage of the challenged legislation and require that those receiving service from Delaware Valley hospital members of plaintiff class—including Blue Cross subscribers—must be responsible for the hospitals' legitimate cost of rendering those services.

WHEREFORE, plaintiffs pray that this Court:

(1) issue an order convening a three-judge district court as required by 28 U.S.C. §§ 2281 and 2284;

(2) advance this action on the docket and order a speedy hearing of this action according to law, and upon such hearing enter an order;

(a) declaring Act No. 94 unconstitutional for the reasons set forth in this amended complaint;

(b) enjoining preliminarily pending final resolution of this action, and permanently thereafter, enforcement and application of the Act insofar as it violates the constitutional rights of any of the members of plaintiff class as set forth in this complaint;

(c) enjoining preliminarily pending final resolution of this action defendant Blue Cross from taking any

action which would penalize members of the plaintiff class for raising a challenge to the constitutionality of Act No. 94; and

(d) granting such other and further relief as may be appropriate in the circumstances.

/s/ JAMES D. CRAWFORD

FRANK H. ABBOTT
JAMES D. CRAWFORD
SUSAN L. CARROLL
Attorneys for Plaintiff

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102

Of Counsel

Dated: September 12, 1975

(title omitted in printing)

MOTION TO INTERVENE AS PLAINTIFFS

Williamsport Hospital, Delaware Valley Hospital Association and Hospital Association of Pennsylvania move for leave to intervene as plaintiffs in this action in order to assert the claims set forth in the attached Complaint, on the ground that their challenge to the constitutionality of Act No. 94 presents issues of law and fact

in common with those arising from the claims of the original plaintiffs.

/s/ JAMES D. CRAWFORD

FRANK H. ABBOTT
JAMES D. CRAWFORD
SUSAN L. CARROLL

Attorneys for Williamsport Hospital, Delaware Valley Hospital Association, Hospital Association of Pennsylvania, Applicants for Intervention

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19107

Of Counsel

(title omitted in printing)

MOTION BY PLAINTIFFS TO ADD DEFENDANT

Plaintiffs move this Court for an order making the Insurance Department of the Commonwealth of Pennsylvania a party defendant herein and directing the issuance and service of process upon it, upon the following grounds:

1. This is an action for a declaratory judgment and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202 declaring Act No. 94, Act of August 2, 1975, amending § 6124 of Title 40 of the Pennsylvania Consolidated Statutes, repugnant to the Constitution of the United States and enjoining its enforcement against plaintiffs.

2. By the terms of Act No. 94, contracts specified thereunder may not be terminated without the prior approval of the proposed additional defendant which, therefore, is a proper party defendant to an action seeking to declare unconstitutional and enjoin enforcement of the Act insofar as it purports to confer authority on the Insurance Department of the Commonwealth of Pennsylvania to impair plaintiffs' contractual rights of termination.

3. The said Insurance Department of the Commonwealth of Pennsylvania is subject to the jurisdiction of this Court as to both service of process and venue, and can be made a party defendant herein without depriving the Court of jurisdiction.

/s/ JAMES D. CRAWFORD

FRANK H. ABBOTT
JAMES D. CRAWFORD
SUSAN L. CARROLL

Attorneys for Williamsport Hospital, Delaware Valley Hospital Association, Hospital Association of Pennsylvania, Applicants for Intervention

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102

Of Counsel

(Proposed Order and Certificate of Service Omitted)

EXHIBIT A

BLUE CROSS OF GREATER PHILADELPHIA

August 5, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE DVHC REPRESENTED HOSPITALS

Dear Sir:

On August 2, 1975, Governor Shapp signed into law Act No. 94 which requires that contractual relationships between hospitals and non-profit hospital plan corporations may only be terminated pursuant to that legislation. Accordingly, since the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement"), has not been so terminated, we will immediately move to take such administrative action as is necessary and appropriate in light of the reinstatement of the Agreement.

In that regard, it is requested that you immediately file your fiscal 1975-1976 budgets on the approved forms as required by Section 18 of the Agreement. Upon receipt of this information we will undertake the budgetary review process and thereafter establish, as appropriate, revised inpatient interim per diem rates. Furthermore, we are reviewing all Blue Cross cases which were previously paid on a non-member indemnity basis directly to Subscribers. At such time as this process has been completed, we will promulgate the administrative procedures we propose to follow in making any required retroactive payment, including restoration of the advances contemplated by the 1973 Summary of Principles.

Commencing immediately Blue Cross will make daily payments to all hospitals pursuant to the Agreement for

Covered Services rendered Subscribers on a current basis. These payments shall be based on the present interim inpatient per diem rates, which amounts will be adjusted when the budgetary information requested above has been received and approved. By your acceptance of these payments, you will be deemed to have agreed with us that such represent full payment for these cases, both inpatient and outpatient, subject only to the adjustments required by the Agreement, notwithstanding any subsequent decision as to the applicability or constitutionality of Act No. 94 to the Agreement or these cases. Moreover, each check representing such payment shall contain a restrictive endorsement indicating that such is made pursuant to this understanding and represents your full concurrence thereto. This policy is being adopted to eliminate any question as to the obligation of Blue Cross to make duplicate payments to the Provider and Subscriber for the same Covered Services.

The teletype confirmations which Blue Cross provides hospitals in response to inquires as to a given Subscriber's benefits shall, for the remainder of this month, indicate by the addition of a double asterisk (**) after their name those individuals who would have been entitled to member benefits without Act No. 94. This identification procedures is intended to quickly identify such cases for your continuing records.

If after reviewing the foregoing you have any question as to the methodology or procedure that Blue Cross intends to follow, please feel free to contact our offices.

Very truly yours,

/s/ Howard W. Baker,
Howard W. Baker, M.D.
Vice President

HWB:ccb

EXHIBIT C

BLUE CROSS OF GREATER PHILADELPHIA

August 20, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE
DVHC REPRESENTED HOSPITALS

Dear Sir:

Today the plaintiffs in *Guest, et al.* v. *Fitzpatrick, et al.*, Civil Action No. 75-2306, withdrew their request to have the United States District Court for the Eastern District of Pennsylvania enjoin the use by Blue Cross of the payment procedures described in my letter of August 5, 1975 (an additional copy of our letter of August 5, 1975 is enclosed for your convenience). Accordingly, since it is necessary that Blue Cross not be exposed to the obligation to make duplicate payments to the Provider and Subscriber for the same Covered Services, checks will continue to be issued with a restrictive endorsement.

However, it appears that there may be some misunderstanding concerning the purpose, scope and effect of the payment procedure adopted.

While Blue Cross will support the constitutionality of Act No. 94 in the pending litigation, there is no intention that the negotiation or transfer of Blue Cross checks will deprive any hospital payee of its right, should it desire to do so, to challenge the constitutionality of Act No. 94 generally or, once having cashed one or more Blue Cross checks with respect to certain admissions, to change its policy and refuse to accept and negotiate checks with respect to future or other admissions.

The purpose of the payment procedure is simply to eliminate the uncertainty produced by the attack on Act No. 94 by reaching a mutually-agreed settlement as to the payments to be made by Blue Cross and a subscriber to the Provider with respect to *only* those admissions covered by the particular check in question.

By negotiating or transferring a Blue Cross check which refers to this letter, the Provider will be agreeing that payment by Blue Cross under the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement") will be the only payment which the Provider will seek with respect to the particular admissions covered by the check in question, and that the Provider will not, *as to those particular admissions only*, make any direct claim against the subscriber not permitted by the Agreement.

We hope you will agree that this is a practical and responsible arrangement in light of the pending uncertainty over the status of Act No. 94.

If, after reviewing the foregoing, you have any questions as to the payment procedures which Blue Cross intends to follow, please feel free to contact our offices.

Very truly yours,

/s/ Howard W. Baker

Howard W. Baker, M.D.
Vice President

HWB:bts
Enclosure

Restrictive Endorsement

Front

"This check is drawn against funds on deposit with the drawee in a special account and is valid and payable by the drawee only when the form of agreement printed on the reverse side hereof has been subscribed to by the payee named hereon without any deletion or alteration whatsoever in such form."

Back

"The payee intending to be legally bound hereby agrees that by this negotiation or transfer of this instrument the payee named hereon agrees that it has accepted and will be bound by the provisions of the drawer's letter of August 6, 1975 to the payee relating to Act No. 94."

BLUE CROSS OF GREATER PHILADELPHIA

August 21, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE
DVHC REPRESENTED HOSPITALS

Dear Sir:

Under the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement") which has been reinstated by Act No. 94, Blue Cross is obligated to provide your hospitals with current financing (i.e.,

working capital advances). We desire to reinstate these advances as soon as practical, but we are faced with the uncertainty created by the pending litigation challenging the constitutionality of Act No. 94.

In the event Act No. 94 is declared unconstitutional, it will, of course, be appropriate for such advances to be returned to Blue Cross. Since in such an event Blue Cross will not be holding amounts payable to a hospital out of which to recover the advance, and since the very existence of the advance is a recognition on the part of a hospital of the need for working capital, effective provisions for repayment of these advances raises significant practical problems.

One option would be for a hospital to give Blue Cross appropriate security for prompt repayment of the advances, and we stand ready to discuss these arrangements on an individual basis, recognizing that Blue Cross will need to be provided with security of a quality and availability comparable to that contemplated by the Agreement under normal termination circumstances.

Recognizing that in some situations a hospital will not be in a position to offer such security, we believe that equivalent security would exist if a Provider agrees that in the event Act No. 94 is declared unconstitutional, it will thereafter voluntarily handle sufficient new admissions under the Agreement to exhaust the amount of the advance then outstanding. This is similar to the normal termination of the Agreement and should in general be fully compatible with your existing financing arrangements and restrictions.

In order to expedite payment of the advances, they are being tendered to you on the assumption that the arrangements stated in the previous paragraph are acceptable to you, and by negotiating or transferring the check or checks representing such advances you will be

deemed to have agreed to such contingent repayment arrangement.

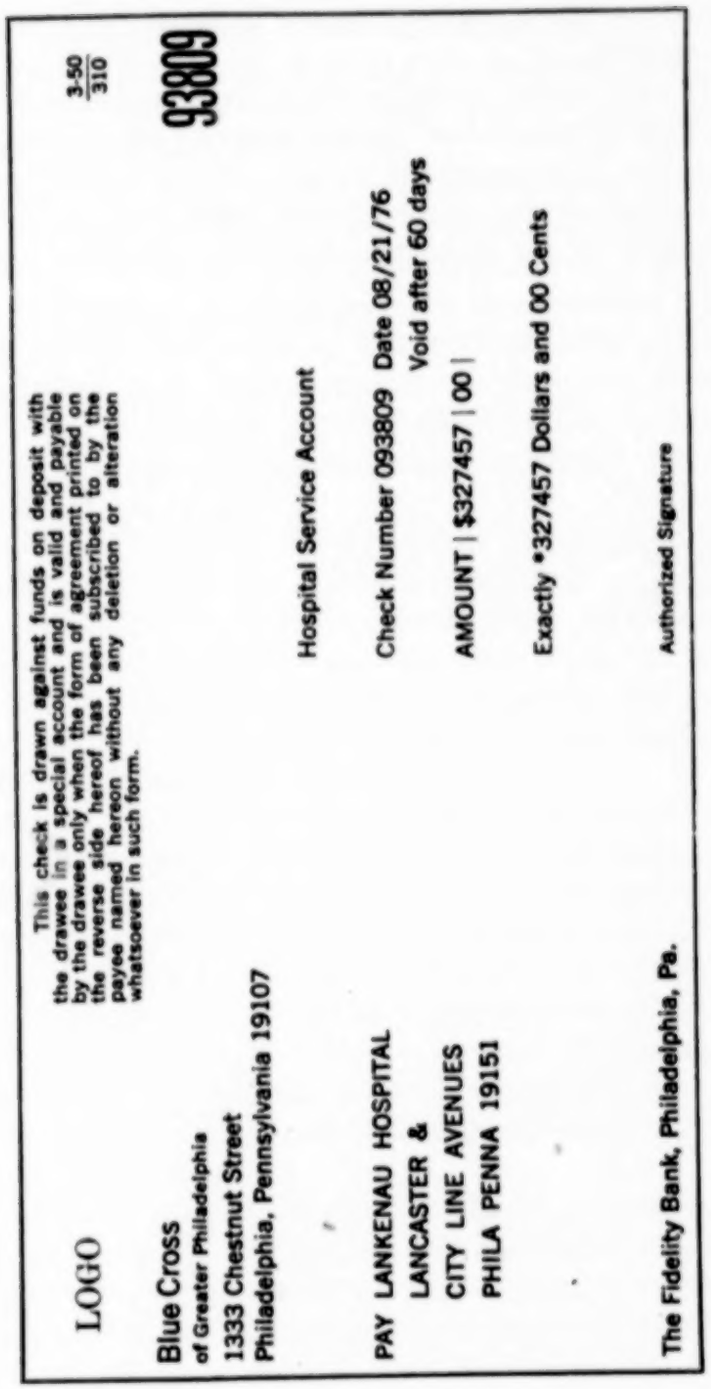
If you prefer to make other arrangements for security which is equivalent to the security which would exist under the Agreement in a case of normal termination, you should return the enclosed check, and advise us of the nature of the security which you can make available.

Very truly yours,

/s/ HOWARD BAKER

Howard W. Baker, M.D.
Vice President

HWB:bts
Enclosure



LOGO

Blue Cross
of Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

This check is drawn against funds on deposit with the drawee in a special account and is valid and payable by the drawee only when the form of agreement printed on the reverse side hereof has been subscribed to by the payee named hereon without any deletion or alteration whatsoever in such form.

3-50
310

93809

Hospital Service Account

Check Number 093809 Date 08/21/76
Void after 60 days

AMOUNT | $327457 | 00 |

Exactly *327457 Dollars and 00 Cents

PAY LANKENAU HOSPITAL
LANCASTER &
CITY LINE AVENUES
PHILA PENNA 19151

Authorized Signature

The Fidelity Bank, Philadelphia, Pa.

BLUE CROSS OF GREATER PHILADELPHIA

August 26, 1975

TO: THE CHIEF EXECUTIVE OFFICER OF
EACH DVHC REPRESENTED HOSPITAL

Since August 2, 1975 when Act No. 94 became law, we have been processing cases currently submitted to us for services to Blue Cross subscribers by your hospital. In other words, we have been transmitting eligibility information to you for the in-patient admissions and are paying you for these cases upon receipt of your billings. Likewise, we have been processing the current out-patient billings for payment to you. Therefore, it does not appear that there should be any difficulty on either our part or yours in the administration of Act No. 94 with respect to cases processed on or after August 2, 1975.

However, processing will be more difficult when dealing with prior cases and will require performance of a number of actions both by our staff and your business office personnel. We believe that the administrative procedures listed below will provide the quickest and most effective method whereby we can jointly accomplish what must be done with respect to *prior cases* affected by Act No. 94.

In-Patient Cases:

There are three possible categories into which these cases can be classified:

Category #1—Cases reported to Blue Cross but our non-member allowances had not yet been paid to subscribers:

Step A—You will receive approval forms from us within the next few days for each such

case. No action is required from you to obtain these approvals.

Step B—Your billings for these cases can then be submitted to us. They do not have to be separately identified by you.

Step C—Our reimbursement will be included in our daily payments to your hospital.

Category #2—Cases for which Blue Cross has already paid the non-member allowances to the subscribers:

Step A—You will receive approval forms from us for each such case. No action is required from you to obtain them. Since it will be necessary for us to prepare new computer programs in order to reconstruct this information, it will take approximately seven days to get these approval forms to you.

Step B—Based on the approval information, you can then process your billings for these cases in the usual manner and send them to us. They do not have to be separately identified by you.

We realize that you may have previously sent billings to us for many of these cases in this category; however, since they were prepared without any eligibility information from us, they did not include the Blue Cross allowance amounts for each class or charge (needed by both of us for final cost settlement purposes) nor did they reflect co-pay amounts required from subscribers.

Step C—Our reimbursement for these cases will be included in our subsequent daily remittances to your hospital. The reimbursements will

be reduced by any non-member allowances already paid by us for these cases. Separate detailed listings of these non-member payments will accompany each remittance to enable you to identify the cases to which they apply.

Category #3—Cases which were not previously reported to Blue Cross:

We believe that some in-patient cases with prior admission dates may not have been reported to us either by hospitals or subscribers. If, after receiving the approvals for categories 1 and 2 above, there are any other cases on your records for which you still lack approvals, please be sure to send us admission notices as soon as possible. Then Steps A, B and C listed under Category #1 should be followed.

Out-Patient Cases:

The out-patient cases can be classified into the same three categories as those described above for in-patient cases. However, the administrative procedures for accomplishing payment of prior cases can largely be accomplished by Blue Cross through some special programs which will be developed for our computer.

Category #1—Cases reported to Blue Cross but our non-member allowances had not yet been paid to the subscribers:

No action is required on your part, even though we may have previously returned the original out-patient billing forms to you. We have all the data needed to reimburse you for these cases and will begin processing them for payment to you this week.

Category #2—Cases for which Blue Cross has already paid the non-member allowances to the subscribers:

> Again, no action is required on your part. We will reprocess these cases as quickly as possible and you will receive payment for them in our subsequent daily remittances. The reimbursement will be reduced by any non-member allowances already paid by us for these cases. Separate detailed listings of these non-member payments will accompany each remittance to enable you to identify the cases to which they apply.

Category #3—Cases which were not previously reported to Blue Cross:

> We believe that some out-patient cases may not have been reported to us either by hospitals or subscribers. If, after receiving the payments for categories 1 and 2 above, there are any other cases on your records which have not been resolved, please be sure to send us out-patient billing forms as soon as possible so that we can process them for payment.

The combination of information on the approval forms, listings of non-member payments and your own records will enable you to determine whether a refund is due the subscriber or a further billing to the subscriber is appropriate.

The foregoing procedures contemplate that where Blue Cross has already paid a non-member allowance to a subscriber, the Provider may, of course, seek payment from the subscriber of an amount equal to the allowance. In order that there may be no question on this point, however, the fifth paragraph of my letter of August 20, 1975 is hereby modified to recognize and permit the practice of

collection by a Provider from a subscriber of an amount equivalent to any non-member allowance deducted from a daily remittance to the Provider. Reference on daily remittance checks to my letter of August 20, 1975 will hereafter be deemed to be a reference to such letter as modified by this paragraph.

A copy of this letter is being mailed to your Business Office Manager. Our Provider Relations Representative will be glad to answer any questions your Business Office may have about the procedures described above.

Very truly yours,

/s/ HOWARD BAKER

Howard W. Baker, M.D.
Vice President

HWB:ccb

SCHNADER, HARRISON, SEGAL & LEWIS

August 21, 1975

William Zeiter, Esquire
Morgan, Lewis & Bockius
123 South Broad Street
Philadelphia, PA. 19109

Re: Blue Cross letter of August 20, 1975 to Chief Executive Officers

Dear Mr. Zeiter:

The purpose of this letter is to confirm your statement to me of today that by cashing the checks referred to in your letter, the hospitals agree not to pursue any claims against the subscribers for whom Blue Cross has made payment, and Blue Cross agrees that even if Act 94 is held to be unconstitutional Blue Cross will not claim any refund of the monies paid. Furthermore, it is understood the cashing of the checks would have no effect on retroactivity of our current negotiations.

Sincerely yours,

/s/ Frank H. Abbott

Frank H. Abbott
For Schnader, Harrison, Segal & Lewis

MORGAN, LEWIS & BOCKIUS

August 22, 1975

Frank H. Abbott, Esquire
Schnader, Harrison, Segal & Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102

Re: Blue Cross letter of August 20, 1975 to Chief Executive Officers

Dear Mr. Abbott:

The first sentence of your letter of August 21, 1975 correctly summarizes the substance of our recent telephone conversation.

I am not clear as to the meaning of "retroactivity of our current negotiations" in the second sentence of your letter, but since I take it that it relates to a subject beyond the scope of the matters mentioned in the first sentence of your letter, you are correct that cashing of the subject checks would have no effect thereon.

With kindest regards,

Sincerely,

/s/ William E. Zeiter

William E. Zeiter

sk

cc: David S. Markson, Esquire

SCHNADER, HARRISON, SEGAL & LEWIS

August 27, 1975

Mr. Bruce Taylor
Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, PA. 19107

Dear Bruce:

The purpose of this letter which is being sent on behalf of all the hospitals represented by the Delaware Valley Hospital Council in the current negotiations which Blue Cross is to inform you that the hospitals refuse to accept the terms and conditions set forth in Dr. Baker's letters of August 5, August 20 and August 21, 1975.

Act No. 94 makes no provisions for Blue Cross unilaterally making restrictions on the payments it makes to the hospitals. If anyone is to impose restrictions, it shall be the Court, by whose holding the hospitals will abide.

Accordingly, the hospitals refuse to accept or be bound by the restrictive endorsements on the checks being issued and the terms and conditions set forth in the letters. We have been instructed to inform you that on September 2, 1975 the hospitals will cash all checks in their possession and if you insist that the restrictive endorsements are binding, it is up to you to stop payment on the checks before September 2, 1975.

With best regards,

Sincerely yours,

/s/ FRANK H. ABBOTT

FRANK H. ABBOTT
FOR SCHNADER, HARRISON, SEGAL & LEWIS

August 27, 1975

HOSPITALS REPRESENTED BY THE
DELAWARE VALLEY HOSPITAL COUNCIL

Abington Memorial Hospital
All Saints Hospital
Booth Maternity Center
Bryn Mawr Hospital
Bryn Mawr Rehabilitation Center
Clement Atkinson Memorial Hospital
Crozer Chester Medical Center
Delaware County Memorial Hospital
Delaware Valley Hospital
Doylestown Hospital
Episcopal Hospital
Frankford Hospital
Germantown Dispensary & Hospital
Holy Redeemer Hospital
Jeanes Hospital
John F. Kennedy Memorial Hospital
Lankenau Hospital
Magee Memorial Hospital
Memorial Hospital, Roxborough
Mercy Catholic Medical Center Misericordia Division Fitzgerald Mercy Division
Methodist Hospital
Montgomery Hospital
Nazareth Hospital
Northeastern Hospital
Paoli Memorial Hospital
Phoenixville Hospital
Presbyterian-University of Pennsylvania Medical Center
Riddle Memorial Hospital
Sacred Heart Hospital, Chester
Sacred Heart Hospital, Norristown
Saint Christopher's Hospital for Children
Saint Joseph's Hospital
Suburban General Hospital
Taylor Hospital
West Park Hospital
Wills Eye Hospital

BLUE CROSS OF GREATER PHILADELPHIA

August 27, 1975

Frank H. Abbott, Esq.
Schnader, Harrison, Segal and Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102

Dear Frank:

This will respond to your letter of August 27, 1975 (copy attached) relating to negotiation of Blue Cross checks.

As you know from your participation in proceedings before the United States District Court for the Eastern District of Pennsylvania in *Guest et al* v. *Fitzpatrick et al,* Civil Action No. 75-2306, Blue Cross is exposed to a substantial risk of duplicate payment liability if Public Act No. 94 is held invalid.

In absence of the Act our obligation with respect to admissions in Delaware Valley Hospital Council represented institutions is solely to pay the non-member benefit to our Subscribers. Under the Act our obligation is to pay the Provider institution.

As you also know, the District Court, when considering your attack on our payment practices, made clear that Blue Cross has every right to protect the Plan against the risk of duplicate payment in the present uncertain circumstances. As a community agency responsible to our subscribers and the Pennsylvania Insurance Commissioner, we cannot permit large contigent liabilities for duplicate payments to accrue. Instead we have adopted procedures which permit the establishment of a definitive payment program for Providers; one which permits Blue Cross, the Subscriber and the Provider to

know immediately the economic consequences of a particular admission. In view of the indefinite time which a challenge to the validity of Public Act No. 94 will doubtless consume, and the availability throughout the community of a substantial number of member hospitals whose status is unaffected by the validity or non-validity of Act No. 94, such a clarification of the status of admissions to DVHC hospitals is clearly in the public interest.

Accordingly your counteroffer, as contained in your letter of August 27, 1975 must be, and is hereby, rejected. Any negotiation or transfer of our checks bearing reference to Dr. Baker's letters of August 5, August 20, August 21 and/or August 26, 1975 will be deemed an offer by the payee hospital to accept settlement with Blue Cross on the basis set forth in the applicable provisions of Dr. Baker's above-mentioned letters. In addition, because of the mechanical problems incidential to the administration of our Hospital Service Account, we could consider any further counteroffers on behalf of a payee hospital only when the counteroffer is accompanied by the return uncashed to Blue Cross of the Blue Cross check or checks to which the counteroffer relates.

Yours very truly,

/s/ Bruce Taylor

Bruce Taylor
President

BT:ccb

cc: CHIEF EXECUTIVE OFFICERS OF THE
DVHC REPRESENTED HOSPITALS

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 75-2306

PAUL I. GUEST, et al.,
Plaintiffs,

v.

F. EMMETT FITZPATRICK, et al.,
Defendants.

ORDER ADDING PARTY DEFENDANT AND GRANTING LEAVE TO INTERVENE AS PLAINTIFFS

This cause coming on to be heard on the motion of plaintiffs for an order making the Insurance Department of the Commonwealth of Pennsylvania an additional party defendant herein, and upon the motion of Williamsport Hospital, Delaware Valley Hospital Council and Hospital Association of Pennsylvania for leave to intervene as parties plaintiff, and it apearing to the Court that said Insurance Department of the Commonwealth of Pennsylvania is a proper party defendant in this action which may be served with process and joined without depriving this Court of jurisdiction, and that said Williamsport Hospital, Delaware Valley Hospital Council and Hospital Association of Pennsylvania should be permitted to intervene as prayed,

IT IS ORDERED:

That the Insurance Department of the Commonwealth of Pennsylvania be made a party defendant to this action; and that the caption of this action shall be amended in

accordance with the foregoing Amended Complaint, which has been filed and served upon the Insurance Department of the Commonwealth of Pennsylvania and the parties defendant, time to move, answer or otherwise plead to be in accordance with the agreement of the parties as approved by the Court.

AND IT IS FURTHER ORDERED:

That Williamsport Hospital, Delaware Valley Hospital Council and Hospital Association of Pennsylvania have leave to intervene in this action and are hereby made parties to this action in accordance with the foregoing Amended Complaint, already filed and served.

/s/ CHARLES R. WEINER
J.

Dated: September 19, 1975

Civil Action No. 75-2306

PAUL I. GUEST, President of Methodist Hospital; CHARLES H. FRENZEL, Executive Vice President of Mercy Catholic Medical Center; et al., etc.,

Plaintiffs,

v.

EMMETT F. FITZPATRICK, JR., District Attorney of Philadelphia, ROBERT P. KANE, Attorney General for the Commonwealth of Pennsylvania, Individually and in their Official Capacities and Blue Cross of Greater Philadelphia,

Defendants.

ORDER CONSTITUTING A THREE-JUDGE COURT

Pursuant to the provisions of Section 2284, Title 28, United States Code, I designate the Honorable Francis L. Van Dusen, United States Circuit Judge, and the Honorable Alfred L. Luongo, United States District Judge, to sit with the Honorable Charles R. Weiner, United States District Judge, as members of the Court for the hearing and determination of the above captioned matter.

/s/ COLLINS J. SEITZ

COLLINS J. SEITZ
Chief Judge
Third Judicial Circuit

Dated: September 30, 1975

(title omitted in printing)

MOTION FOR SUMMARY JUDGMENT
BY PLAINTIFFS AND PLAINTIFFS-INTERVENORS

Plaintiffs and plaintiffs-intervenors move this Court to enter, pursuant to Rule 56 of the Federal Rules of Civil Procedure, a summary judgment in their favor for the declaratory and injunctive relief prayed for in their Amended Complaint on the ground that there is no genuine issue as to any material fact and that they are entitled to a judgment as a matter of law for any or all of the following reasons:

a. The Act of August 2, 1975, Act 94, reinstates previously terminated contracts and authorizes the extension of pre-existing contracts, which retrospective application of the Act substantially alters and increases plaintiffs' obligations under those contracts in violation of both the Contract and Due Process Clauses of the Constitution of the United States;

b. In both its retrospective and prospective applications, Act 94 forces plaintiffs to provide service at non-compensatory rates and, thus, effects an unconstitutional confiscation of property and denies to those in plaintiff hospital class equal protection of law; and

c. The retrospective and prospective applications of Act 94 are so interdependent as a matter of both statutory construction and legislative intent that even if the Act is found to be unconstitutional only in its retrospective application, the entire Act must be stricken.

This motion is based upon

a. the Amended Complaint,

b. the attached affidavit, and

c. the Memorandum of Plaintiffs and Plaintiffs-Intervenors in Support of Motion for Summary Judgment.

/s/ FRANK H. ABBOTT

FRANK H. ABBOTT
JAMES D. CRAWFORD
SUSAN L. CARROLL
Attorneys for Plaintiffs and Plaintiff-Intervenors

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102

Of Counsel

Dated: October 7, 1975

(Certificate of Service Omitted in Printing)

COMMONWEALTH OF PENNSYLVANIA }
COUNTY OF PHILADELPHIA } SS.

EDWARD J. ARMSTRONG, being duly sworn according to law, deposes and says the following based on his personal knowledge thereof:

1. That he is the Administrator of Jeanes Hospital, a non-profit corporation organized under the laws of Pennsylvania and located at 7600 Central Avenue, Philadelphia, Pennsylvania 19111.

2. That he is responsible for maintaining the fiscal viability of Jeanes Hospital and has final authority for recommending to the board of trustees a schedule of patient charges in accordance with this purpose; he has discharged essentially these duties under various titles for 15 years.

3. That legitimate patient charges are based on the true total cost associated with services provided that patient which cost includes, in addition to expenses incurred in the actual treatment of the individual patient, a pro rata share of the cost of maintaining the hospital and performing its duties of public service to the community to the extent that these costs are otherwise unreimbursed.

4. That a non-profit hospital must allocate among charges to paying patients the otherwise unreimbursed costs of community service activities and its own main-

tenance expenses or it cannot remain financially solvent and continue to perform its obligations to the extent and at the level required by law in accordance with the basic purposes of a non-profit medical institution.

5. That on July 1, 1971, Jeanes Hospital entered into a contract with Blue Cross of Greater Philadelphia ("Blue Cross"), which contract with amendments thereto is referred to in the Amended Complaint as the Delaware Valley Agreement.

6. That under this Agreement, Blue Cross agreed to pay Jeanes Hospital the reasonable cost of covered services furnished its subscribers, but no part of the expenses incurred by the hospital in providing care to indigents, in writing off uncollectible accounts other than those of Blue Cross subscribers, in providing charity allowances, and in undertaking certain educational and research activities.

7. That, as regards payment under the contract as reinstated by Act 94, Blue Cross has directed Jeanes Hospital that unless it is willing to negotiate a new payment ceiling, *i.e.* a percentage limitation over allowable costs for the previous year, it will be reimbursed in accordance with the ceiling limitation contained in a 1974 Agreement negotiated by Blue Cross with entirely different parties. This unilateral policy was announced in a letter to Jeanes Hospital identical to that included at Exhibit "C" to the Memorandum of Plaintiffs and Plaintiffs-Intervenors in Support of Motion for Summary Judgment.

8. That the costs which Blue Cross does not define as reasonable and will not reimburse, and that further proportion of costs defined as reasonable but which might exceed the ceiling limitation on Blue Cross payments, are costs which would normally be allocated among all of the

paying patients at Jeanes Hospital in accordance with accepted accounting procedures.

9. That Blue Cross' refusal to recognize these costs results in a loss to Jeanes Hospital which must then either be allocated among the remainder of its paying patients who are not Blue Cross subscribers, such that this latter group is forced to pay more than their share of the community service and hospital maintenance costs which are not recoverable under the Delaware Valley Agreement for service rendered Blue Cross subscribers, or must be carried as losses.

10. That because of its relatively small indigent patient population, the loss suffered by Jeanes Hospital as a result of reduced costs payable by Blue Cross is smaller than that sustained by nearly every other hospital in the Delaware Valley, but still amounts to more than $50,000 a year.

11. That this loss is multiplied over time because, although Blue Cross will pay its shares of depreciation of hospital buildings and equipment, the portion of its payment which should be segregated, funded and invested towards future replacement costs, must necessarily be used by Jeanes Hospital to meet those of its immediate operational expenses which Blue Cross will not pay. Thus, the hospital loses the accumulated interest it would have earned had the money earmarked for depreciation been available for investment. Further, since Blue Cross payments are received on a piecemeal basis, even that portion which can be placed in a depreciation fund cannot possibly be invested at rates which will keep pace with inflation.

12. That for these reasons, although the Jeanes Hospital plant is nearly fully depreciated (having been erected in 1928), the hospital has invested only a fraction of the present replacement cost of its plant. This is a direct

result of the failure of the Blue Cross payment formula to account for an operating growth needs factor, which factor is recognized by Blue Cross in its contracts with hospitals in other states.

13. That a further result of the fact that Jeanes Hospital must borrow against its depreciation funding just to meet its daily costs of operation is that the hospital has almost no cash available for purchases of new equipment and cannot, in accordance with proper fiscal policies, develop reserves which would enable it to keep pace with the rapidly expanding technology in the health care field. Thus, as a result of Blue Cross' partial and after the fact method of payment, the hospital will normally be forced to borrow the purchase price of new equipment. Blue Cross will bear its subscribers' share of this cost through depreciation; however the cost to the entire system—Blue Cross subscriber-patients in common with all paying patients—will be nearly double the cash purchase price of that equipment over a ten year use period at present interest rates. In many cases, rather than impose this cost on the system, the hospital may forego or delay the purchase of new equipment even though its value is well established.

14. That the effect of Blue Cross' failure to reimburse Jeanes Hospital the true total costs of providing service to Blue Cross subscribers is thus two-fold. It results in an immediate loss to the hospital which must be subsidized by increased charges to other paying patients, and it further creates a cash shortage which is projected into the future and multiplied over time to make it impossible for the hospital to account for its operating growth needs and keep pace with rapidly improving technology in hospital equipment.

15. That if all patient care were paid for on the same basis as that provided for in the Delaware Valley

Agreement, Jeanes Hospital would necessarily be unable to provide even the minimal quality of health care services required to maintain its accreditation.

16. That, based on personal knowledge of Blue Cross contracts in other cities and certain statistical studies performed by the American Hospital Association (*e.g.*, a survey compiled by Thomas P. O'Hare and released on February 28, 1974, and another prepared in November of 1971), there appears to be a distinct correlation between the terms on which Blue Cross reimburses member hospitals in various cities and the percentage of the health care insurance market which Blue Cross occupies in those same cities. Thus, the Blue Cross contracts in New York, the District of Columbia, Detroit, Boston and Cleveland are all cost-based as is the Delaware Valley Agreement in Philadelphia. In each of these cities including Philadelphia, Blue Cross enrolls close to or in excess of 50% of those purchasing health care insurance. Conversely, in cities like San Francisco, Phoenix and Houston where Blue Cross operates on an indemnity basis, its share of the relevant market is less than 20%.

The foregoing is true and correct to the best of my personal knowledge.

/s/ EDWARD J. ARMSTRONG

Edward J. Armstrong

(Oath and Jurat Omitted in Printing)

(title omitted in printing)

JOINT MOTION OF THE DEFENDANTS BLUE CROSS OF GREATER PHILADELPHIA, ROBERT P. KANE, ATTORNEY GENERAL, AND THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA FOR A SUMMARY JUDGMENT

1. The plaintiffs in this case contend that the act of August 2, 1975 (No. 94) of the Commonwealth of Pennsylvania is unconstitutional and seek equitable and declaratory judgment relief.

2. The defendants Blue Cross of Greater Philadelphia, Robert P. Kane, Attorney General, and the Insurance Department of the Commonwealth of Pennsylvania contend that the Act is constitutional.

3. Based upon the affidavits in support of this motion and the brief of the defendants, the defendants respectively request that a summary judgment be granted denying the relief requested by the plaintiffs, and a declaration that the Act is constitutional.

/s/ DENIS V. BRENAN

DENIS V. BRENAN

/s/ HOWARD M. HOLMES

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(Certificate of Service Omitted in Printing)

AFFIDAVIT

BRUCE TAYLOR, being duly sworn, deposes and says:

1. I am the President of Blue Cross of Greater Philadelphia and have been associated with this organization since 1939. During this period, I have held positions successively as Accounting Department Unit Supervisor, Administrative Assistant, Assistant Vice President, Vice President and Executive Vice President. Further, I have served as a member of numerous national, regional and local organizations concerned with health care delivery, including acting as an advisor to various United States and Pennsylvania Senate and House Committees, as well as the Social Security Administration.

2. The Blue Cross system, as it is known today, is composed of eighty independent non-profit corporations known as Plans. These organizations, located throughout the United States, Canada, Puerto Rico, and Jamaica provide for the financing of health care benefits to approximately 87 million individuals. When combined with the 32 million people covered under federal government programs administered by Blue Cross Plans, the total number of individuals served by these organizations exceeds 117 million.

3. The Blue Cross concept originated in 1929 when Justin Kimball, then Executive Vice President of Baylor University, developed a pre-paid hospitalization program for Dallas school teachers. Under this program, each teacher paid fifty cents a month to the University Hospital and was in turn assured of receiving up to twenty-one days of hospital care without further charge. Although the Baylor program was an immediate success, being widely copied in other areas, it was apparent that the single hospital—single group program was of limited usefulness,

especially in cities having several hospitals. Thus, in subsequent years groups of hospitals joined together to initiate community-wide pre-payment plans whose growth and acceptance were fostered by the adverse economic situation of the times which otherwise would have precluded many people from obtaining necessary hospital care.

4. Initially the pre-paid hospitalization programs were sponsored by diverse organizations ranging from the council of social agencies to local business groups, community funds, or the hospital council. To bring these various insurance programs under the control of state regulators, statutes were passed in many jurisdictions authorizing the formation of non-profit hospital plan corporations. One of the earliest, the Hospital Service Association of Minnesota, was incorporated in 1933. Its director, Mr. E. A. van Steenwyk, began using a blue cross on his stationery, information folders and posters as an identification symbol for the organization. The symbol gained quick acceptance and it was only a short time later that the Hospital Service Association became known as "Blue Cross".

5. The concept of pre-paid hospitalization coverage was explored in Philadelphia by a group of civic leaders in 1936. As a result of their action, and the efforts of the then Insurance Commissioner, Mr. Owen Hunt, enabling legislation was passed permitting the creation of pre-paid hospital benefit corporations in the Commonwealth of Pennsylvania as the financing mechanism for meeting community needs for hospital care. In 1938, Blue Cross of Greater Philadelphia, then known as The Associated Hospital Service of Philadelphia, was formed with $30,000 borrowed from the Community Chest. In its first year of operation the Plan enrolled 28,000 members. Today, over

three and a half decades later, this total has grown to approximately 2,400,000 subscribers.

6. Subsequent to the formation of the Philadelphia Plan, other Plans were established to cover the remainder of the Commonwealth of Pennsylvania. Today, in addition to Blue Cross of Greater Philadelphia, there are four other Plans serving the citizens of Pennsylvania: Capital Blue Cross (Harrisburg), Blue Cross of Lehigh Valley (Allentown), Blue Cross of Northeastern Pennsylvania (Wilkes-Barre) and Blue Cross of Western Pennsylvania (Pittsburgh). These five Plans currently serve a majority of the residents of Pennsylvania or approximately 6.5 million policyholders, known as Subscribers, dispensing in excess of 600 million dollars annually in benefit payments.

7. The Philadelphia Plan is incorporated under the Non-profit Corporation Law of 1972 and regulated by the Pennsylvania Insurance Department as a hospital plan corporation (40 Pa. C.S. § 6101, *et seq.*), which among other things requires the Insurance Commissioner to approve all hospital contracts and "rates of payments to hospitals". A copy of the Plan's Articles of Incorporation which may be amended only with the approval of the Insurance Commissioner and Governor of the Commonwealth of Pennsylvania are attached hereto as Exhibit 1.

8. The Plan's affairs are guided by a Board of Directors composed of thirty-four individuals elected by vote of Subscribers, and four ex-officio members. Seven of the elected directors are nominated by state and local officials representing the communities the Plan serves. Further, to ensure broad-based representation, only three hospital trustees and three physicians may serve on the Board at any time, and the By-Laws specifically preclude election of any salaried hospital employee other than a physician. The By-Laws, which set forth the duties and

responsibilities of the Plan's officers and directors, are attached hereto as Exhibit 2.

9. Importantly, the By-Laws include provision for an independent Consumer Advisory Committee composed of a cross-section of Subscribers, whose Chairman and Vice Chairman are ex-officio voting members of the Board of Directors. As provided in Section 3.18 of the By-Laws, the nucleus of this Committee is composed of individuals appointed by the Governor of Pennsylvania, Mayor of the City of Philadelphia, President of the Philadelphia City Council, and the Chairman of the respective Boards of Commissioners of Bucks, Chester, Delaware and Montgomery Counties.

10. Blue Cross coverage differs substantially from that provided by a commercial insurance company in the important areas of benefits and method of operation. Blue Cross contracts with its Subscribers on a non-profit basis under either individual or group policies called Subscription Agreements. However, the Plans do not stop there. They then negotiate contracts directly with area hospitals to furnish covered services to Subscribers without charge to these individuals, other than the modest deductible or coinsurance amount which may be required by their respective Subscription Agreements. The contracting hospitals, known as "Member Hospitals", are paid directly by Blue Cross for services rendered Subscribers as provided by their then Blue Cross-Hospital Agreement. Thus, unlike commercial insurance companies, Blue Cross provides service benefits rather than a specified dollar sum or indemnity. The advantage of such coverage is obvious for the charges levied by hospitals vary significantly between hospitals and within a given hospital depending upon the scope of services required for a specific illness. In recent years hospital charges have risen at such rapid rates that

any fixed indemnity coverage would quickly become insufficient.

11. Service benefits do not disappear merely because a Subscriber travels or is treated at a Member Hospital which does not have a contract with the Subscriber's Plan. Recognizing the mobility of our population, the Plans developed what is now known as the Inter-Plan Service Benefit Bank. Through this mechanism, the Plan serving the area in which the Member Hospital is located authorizes the treatment of the Subscriber and then charges the cost back to the Subscriber's Plan through the Bank. A fuller and more complete description of this coordinated effort which ensures national coverage is attached as Exhibit 3.

12. All Plans, including those located in Pennsylvania, are members of the Blue Cross Association, headquartered in Chicago, Illinois. Membership in this organization which establishes national policy, operates the Inter-Plan Service Benefit Bank and licenses the use of the Blue Cross symbol is closely monitored and strict standards of service are imposed on all Plans. A detailed explanation of these procedures is set forth in Exhibit 4, while the 1974 Fact Book included as Exhibit 5 provides extensive data with regard to the overall operations of the 80 individual Plans.

13. In addition to its other functions, the Blue Cross Association also acts as agent for the Individual Plans in arranging national contracts with major corporate employers which have undertaken responsibility for certain uniform benefits to their employees located in various parts of the country as a result of collective bargaining. Further, the Association as prime contractor with the Civil Service Commission sub-contracts with local Plans to provide health care protection for federal employees

under the Federal Employees Health Benefits Program and, as prime contractor with the United States Department of Defense, supervises the program which serves more than a million dependents and retirees of the armed forces through CHAMPUS-Civilian Health and Medical Program of the Uniformed Services.

14. Prior to the July 1, 1966 effective date of Title 18 of the Social Security Amendments which created Medicare (the national health programs for persons 65 and older), the U.S. Department of Health, Education and Welfare signed a contract with the Blue Cross Association designating the Association as "intermediary" between the government and most of the country's voluntary hospitals. Under this accord, and pursuant to subsequent contracts, the Blue Cross Plans perform a wide range of functions in communications, claims processing, utilization review and audit necessary for operation of that portion of Medicare which provides institutional benefits. All Pennsylvania Plans actively participate in this work.

15. The 1965 Amendments to the Social Security Act also included as Title 19, the state-initiated, state and federally financed program of medical assistance for the poor. Locally, the Pennsylvania Plans process claims under this program on behalf of the Commonwealth's Department of Public Welfare and otherwise assist in this state-operated endeavor.

16. For many years most Blue Cross coverage was provided on a group basis through the individual's employer or union. Although this is still the prevailing practice, the Plan has developed several contracts for use by individuals who are not members of a group. Presently, the Philadelphia Plan offers three non-group Subscription Agreements: Co-Pay Preferred Comprehensive (Exhibit 6), $250 Deductible (Exhibit 7), and for those individuals

receiving Medicare benefits, a 65 Special Agreement is available (Exhibt 8). Further, in cooperation with Pennsylvania Blue Shield, the Plan also offers a Non-Group Major Medical Program which can be added to the basic Subscription Agreements (Exhibit 9). Copies of the approvals issued by the Pennsylvania Insurance Department authorizing these policies are included with the respective Subscription Agreements in the accompanying exhibits.

17. Although group contracts vary substantially with regard to the extent and length of coverage, those offered by the Philadelphia Plan contain essentially the same general provisions. A representative group contract is attached as Exhibit 10.

18. Since many "groups" are too small to develop their own representative usage experience, Blue Cross has traditionally issued a non-credible group policy for these organizations; a representative form of which is attached as Exhibit 11. Except as to the method of computing premium rates, the group and non-credible group contracts are essentially the same as both may be modified to meet particular situations or circumstances.

19. Although the Plans contract with substantially all accredited hospitals, some are avoided either because of the hospital's wishes or the Plan's desire not to contract with unsafe or unneeded institutions. Any hospital not contracting with a Plan is known as a "Non-Member Hospital".

20. Although the primary purpose of the Plan is to bring to its Subscribers the benefits of its contracts with Member Hospitals, it also recognizes that individuals may desire because of location or availability, or be required, due to the affiliation of their physician, to seek hospital care at a Non-Member Hospital. Therefore, the Subscrip-

tion Agreements, both group and non-group, contain an indemnity benefit which is payable to the Subscriber in such event. Since this payment may be substantially less than the amount billed by the hospital, such provides far less coverage than the normal service benefit.

21. The Philadelphia Plan initially negotiated rates of reimbursement on a hospital-by-hospital basis so as to achieve a favorable rate differential for Subscribers. Indeed, by the late 1950's most Blue Cross Hospital contracts were cost-related, as was the Standard Blue Cross Member Hospital Contract offered by the Philadelphia Plan. A copy of this agreement, dated July 1, 1958, is attached as Exhibit 12 ("1958 Agreement").

22. Under the 1958 Agreement, reimbursement was initially established by negotiation utilizing cost data with subsequent years' rates made subject to annual escalation based upon the Cost Index derived from published records of the U.S. Bureau of Labor Statistics.

23. With the advent of Medicare in 1966, the then Pennsylvania Insurance Commissioner ordered all Pennsylvania Plans to renegotiate their hospital contracts based on the cost accounting principles which guided Medicare. The outgrowth of that negotiation was the Uniform Cost Contract—1967 ("1967 Agreement"), a copy of which is attached hereto as Exhibit 13. Interestingly, since the 1967 Agreement was not executed until after the commencement of the fiscal year 1968, it was necessarily made retroactive to July 1, 1967.

24. Under the reimbursement provisions of the 1967 Agreement, accountants annually determine the total cost of operating a hospital and the proportion of that cost represented by services utilized for Blue Cross Subscribers. This cost, subject to audit adjustments by independent certified public acountants is then reimbursed to the hospital by the Plan.

25. In 1971, during a public hearing considering proposed increases in Subscriber rates, the then Pennsylvania Insurance Commissioner, Herbert S. Dennenberg, ordered the 1967 Agreement cancelled, and immediate negotiations commenced to develop a new agreement. A copy of the Commissioner's letter confirming this order is attached as Exhibit 14.

26. Subsequent to this action, the Insurance Commissioner promulgated detailed Guidelines, which he indicated must be addressed in any new agreement. These items included further quality control standards designed to insure greater efficiency and economy, increased public accountability, imposition of cost ceilings, and a substantial number of consumer-oriented measures variously described as a patient's "Bill of Rights". A copy of these Guidelines, and the several subsequent additions thereto are included herewith as Exhibit 15. In 1974, when the present Insurance Commissioner, William Sheppard assumed office, he issued a news release advising that the control measures previously mandated by the Insurance Department would be continued. A copy of this release is attached as Exhibit 16.

27. As a result of lengthy arms-length negotiations, attended regularly by representatives of the Insurance Department, including the Commissioner, spanning over a year-and-a-half, a contract was finally achieved between the Philadelphia Plan and area hospitals. This accord, the Hospital Agreement, July 1, 1971 ("1971 Agreement"), is attached as Exhibit 17. Since the 1971 Agreement was not finally executed until 1972, the pattern established with the 1967 Agreement was followed and it was made retroactive to July 1, 1971.

28. Although the specific agreements negotiated by the other Pennsylvania Plans include provisions especially adapted to their service areas, all base reimbursement on

cost and contain quality control provisions responsive to the Insurance Department's Guidelines.

29. Section 18.4 of the 1971 Agreement imposed a specific cost ceiling on the reimbursement payable to Member Hospitals. For fiscal year 1971-1972 any amount exceeding 112% of the cost allowable in the prior fiscal year was disallowed. This Section also contemplated a further contractual limit for fiscal 1972-1973, but with the implementation of the Economic Stabilization Act, it was agreed by the contracting parties that the limitations imposed by the Act would serve as an alternative ceiling. The amendment to the 1971 Agreement, effective July 1, 1972, which adopted this cost ceiling is attached as Exhibit 18.

30. Since the 1971 Agreement was to expire by its terms on June 30, 1973, the Plan, by letter to the hospitals' bargaining unit, the Delaware Valley Hospital Council ("DVHC"), dated December 29, 1972, called for new negotiations. A copy of this letter, setting forth nine specific areas the Plan wished to explore for inclusion in a new contract, is attached as Exhibit 19.

31. At the first negotiating session held in response to the foregoing invitation on March 2, 1973, the Plan's negotiators expanded upon the areas identified in its earlier letter noting the Plan desired to add improved cost containment provisions. For its part, the DVHC's negotiating posture was largely one of seeking to eliminate cost ceilings, while cutting back on the quality controls imposed by the 1971 Agreement.

32. Following thirty-seven lengthy and difficult negotiating sessions, which were frequently attended by representatives of the Pennsylvania Insurance Department, the Plan and DVHC reached tentative agreement on December 26, 1973 as to a one year extension of the 1971 Agreement, that is, through June 30, 1974. A copy of this document,

known as the 1973 Summary of Principles ("1973 Agreement") is attached as Exhibit 20. Under the terms of this accord, the prior practice of making retroactive adjustments was continued, as the effective date of the 1973 Agreement was July 1, 1973.

33. During the period while the Plan was negotiating an extension agreement with the DVHC, the Insurance Department ordered the then existing Blue Cross contract with proprietary hospitals, those operated for profit, to be renegotiated so as to incorporate the quality control provisions included in its Guidelines. A copy of the Commissioner's letter ordering this modification is attached as Exhibit 21.

34. After a relatively short period of negotiations with representatives of the proprietary hospitals, agreement was reached as to a new form of contract which not only responded to the Guidelines, but also the further reforms sought by the Plan in its negotiations with the DVHC. A copy of this contract, known as the 1973 Proprietary Hospital Agreement ("Proprietary Agreement"), is attached as Exhibit 22. Following the practice established with the non-profit hospitals, the Proprietary Agreement was made retroactive.

35. The 1973 Agreement terminated by its own accord on June 30, 1974, but through unilateral extensions granted by the Plan, it was continued through August 15, 1974 in hopes of resolving the negotiating impasse. However, the DVHC steadfastly refused to consider any effective cost containment measures, improved utilization review procedures, or greater patient rights, stating they would not accept any of the new procedures included in the Proprietary Agreement. Indeed, the DVHC, as bargaining agent for these "non-profit" hospitals, argued they would not recommend any contract which did not have a

profit factor, that is, a percentage allowance in excess of the actual cost of Subscriber care.

36. The effectiveness of the extensions granted by the Plan was subsequently challenged by certain of the DVHC represented hospitals in an action instituted in the Court of Common Pleas of Delaware County known as *Crozer-Chester* v. *Blue Cross of Greater Philadelphia* (Docket No. 9799 of 1974). However, this action was subsequently resolved by a Settlement Agreement entered on September 25, 1974, a copy of which is attached as Exhibit 23, whereby the extensions were accepted as valid and binding on the DVHC represented hospitals.

37. Under the terms of the 1971 Agreement, as amended and supplemented by the 1973 Agreement, Subscribers are entitled to continue receiving full service benefits at DVHC represented hospitals until the next anniversary date of their Subscription Agreement with the Plan following the termination of the 1973 Agreement. Thus, large numbers of Subscribers were granted continued service benefits at these institutions up until August 15, 1975. Payments to the hospitals for services rendered to a gradually decreasing proportion of the Plan's Subscribers during that period were made as provided in the 1973 Agreement, as supplemented by the Settlement Agreement.

38. Since the impact of the termination was not immediately felt by most Subscribers, the effect on the Philadelphia area hospital delivery system was gradual but significant. When a Subscriber, whose anniversary date had passed, attempted to obtain hospital services he was confronted with a request for a cash deposit, pledge or other security. No longer did the Blue Cross card ensure the individual that his bill could and would be paid. Rather, Subscribers seeking to use these now Non-Member Hospitals were faced with the prospect of either paying

bills, which in some cases exceeded their total net worth, or deferring necessary hospital care.

39. Although the assured cash flow the hospitals had traditionally received from Blue Cross was slowly reduced as more Subscribers lost service benefits, the hospitals, in many cases, were not adversely affected. The termination of the 1973 Agreement meant these now Non-Member Hospitals could charge patients whatever they wished. Absent a contract, cost no longer was the guide to reimbursement. Recognizing that patients select a physician and not a hospital, most Subscribers continued to enter community hospitals, whether they were Member or Non-Member. This admission practice, when coupled with the unlimited charges the hospital could command, did not make the negotiation of a new contract desirable. The result of this turn of events was to diminish the quality controls, cost containment measures and patient rights which Blue Cross and the Insurance Department had labored long to achieve.

40. Recognizing that this development was not in the best interests of the communities they serve, all Philadelphia medical school hospitals, as well as a number of community hospitals, abandoned the DVHC position. A statement issued by the medical school hospitals on August 14, 1974 explaining their position and reasons for seeking separate negotiations with the Plan is attached as Exhibit 24.

41. Following a relatively short period of negotiations with this independent group of hospitals, their representatives reached a contractual understanding with the Plan which was embodied in a document entitled "Memorandum of Agreement", a copy of which is attached as Exhibit 25. This understanding incorporated many of the principles sought by the Plan during its negotiations with the DVHC, but also added several new concepts reflective of

today's economic situation. For example, a flexible cost ceiling developed by the Wharton School at the University of Pennsylvania was included, together with incentive payments for increased efficiency and more comprehensive utilization review.

42. Subsequently, a formal accord was drafted incorporating the various principles contained in the Memorandum of Agreement and such was approved by the Pennsylvania Insurance Department ("1974 Agreement"). A copy of the 1974 Agreement with the approval letter of the Insurance Department is attached as Exhibit 26. Again, as was the pattern with prior accords, this Agreement was made retroactive.

43. Although the 1974 Agreement was offered all hospitals represented by the DVHC, most have rejected it notwithstanding the recommendations of organized labor, the Greater Philadelphia Chamber of Commerce, and Greater Philadelphia Movement. Copies of the letters from these labor, business and community organizations expressing their accord with the Blue Cross' position are attached hereto as Exhibit 27.

44. Early in 1975, in an effort to lift the negotiation stalemate between the Plan and DVHC represented hospitals, the Pennsylvania Insurance Department intervened as a mediator, unfortunately without success. Similarly, although Governor Shapp personally entered the negotiations, participating in three full-day sessions, an agreement was not reached as the DVHC negotiators steadfastly insisted upon a profit percentage and abandonment of quality controls as the price of a contract. Attached as Exhibit 33 is a memorandum and letter from the DVHC counsel setting forth their negotiating position.

45. Faced with this health care crisis which could well spread through the Commonwealth, the General Assembly, reacting to the needs of its constituents, passed House

Bill No. 1347 which was subsequently signed into law by the Governor as Public Act No. 94. A copy of the Act is attached as Exhibit 28.

46. Public Act No. 94 recognizes the significant impact discontinuance of Blue Cross coverage would have on the general populace. It requires that hospital contracts may only be terminated after notice is first given the Pennsylvania Insurance Department, which in turn is afforded an opportunity to initiate fact-finding, call negotiations, conduct public hearings, and finally to recommend appropriate solutions. During this period, the terminated contract is reinstated and continued. Since that contract is cost-based, such does not preclude the hospitals from receiving increased reimbursement during the "cooling-off period".

47. In the event a new contractual arrangement is finally achieved between the Plan and the terminating hospitals, Public Act No. 94 requires that such be made retroactive. This treatment would merely continue what has been the past practice of the Philadelphia Plan and routinely approved by the Insurance Department. Indeed, as shown by the DVHC counsel's letter attached as Exhibit 29, retroactivity has always been a hospital demand, and in the referenced letter is made a condition precedent to settlement.

48. The contracts between Pennsylvania Plans and member Hospitals, as previously indicated, are based on accounting principles requiring the actual cost of providing health care to Subscribers be reimbursed by the Plan. Since this arrangement necessarily requires an estimate of future costs if the hospital is to realize essential cash flow, the 1971 Agreement provides in Section 18 for the submission of budgets. These estimates are then reviewed by the Plan's Staff following the procedure described in Exhibit 30. After the budgeted costs are agreed upon by

the Plan and hospital, an interim rate is developed based on the expected number of inpatient days projected for the fiscal period.

49. Since interim payments are made at the time a billing is presented to the Plan following a Subscriber discharge, there is, of course, some lag in payment. In order to reduce this receivable and the hospital's accompanying need for financing, the 1973 Agreement adopted an extensive advance program. This permits any Member Hospital to draw an interest-free advance equal to 15 days of anticipated reimbursement. The hospitals may also request a further 15 day advance, but interest on that sum will be charged by the Plan.

50. As of the end of each fiscal quarter, the hospital submits actual cost reports to the Plan. Based on this experience the interim rate may be adjusted, both retroactively and prospectively. Following the end of a fiscal year, final settlement is made based on actual cost as verified by independent certified public accountants and Subscriber usage for the period.

51. The 1973 Agreement provides that the Plan pay only costs incurred in providing patient care, and then only that portion represented by the ratio of Subscriber usage to total usage by all patients. Thus, any "loss" incurred as a result of services rendered free-care patients, "courtesy" allowances, or on account of services not related to patient care, such is not reimbursed by the Plan.

52. In the event any dispute arises under the 1973 Agreement, provision is made for final judicial review. Indeed, since the expense of legal representation, even that in matters involving Blue Cross, is generally a cost of doing business, the Plan reimburses the litigating hospital for the Blue Cross share of this expense.

53. The per diem costs, actual and project, for Philadelphia area hospitals have exhibited a dramatic rise in recent years. As shown in the chart attached as Exhibit 31, this cost has risen from $29.27 in 1964 to $117.83 for 1974. Importantly, this cost is projected to reach $201.25 in 1977. Clearly, without some form of limitation, be it contractual or regulatory, the cost of patient care will soon outstrip the means of many individuals. The 1971 and 1973 Agreements were instrumental in holding down costs, and as shown by Exhibit 32, worked to reduce the number of in-patient days by means of improved utilization review, provided penalties for medically unnecessary procedures and contained other consumer-oriented measures. However, with the removal of these contractual controls, costs and length of stay can again be expected to soar.

54. The Pennsylvania General Assembly has recognized the significant impact of rising hospital costs and has considered over the past few years several bills designed to establish direct regulation over hospital rates. Representative copies of these Bills are attached as Exhibit 33.

55. Regulation of hospital rates is not unique nor novel as the neighboring state of New Jersey, where the Philadelphia Plan currently contracts with a number of hospitals, has adopted legislation whereby the Departments of Health and Insurance mutually develop the rates which hospitals may charge Blue Cross Plans. A copy of the pertinent part of this regulatory statute is attached as Exhibit 34.

56. The fact that the hospital plaintiffs in this action are non-profit institutions does not exempt them from regulation by the Commonwealth for only the Pennsylvania Hospital, a Member Hospital, has claimed exemption from the power of the General Assembly pursuant

to the Nonprofit Corporation Law of 1972 (15 Pa. C.S. § 101(c)) by filing a certificate of nonacceptance of the Constitution of Pennsylvania under the Registry Act of 1966 and related legislation.

57. In sum, the Pennsylvania Plans, lacking direct governmental authority to limit hospital cost, have traditionally negotiated cost limitations and quality controls into their contracts with Member Hospitals. These controls are the product of collective bargaining and represent a substantial value for Subscribers. The Pennsylvania Legislature recognizes the success that the Plans have achieved in this voluntary process and encourage this form of development by only indirectly regulating hospital rates, that is, through Insurance Department approval of hospital contracts. However, if this bargaining process is no longer viable, hospital rate setting regulation may be required.

58. Public Act No. 94 does not alter the traditional contractual situation between Pennsylvania Blue Cross Plans and Member Hospitals. Rather, it recognizes their essential relationship and opts for its continuance. If the Insurance Department is finally unsuccessful in bringing the parties together, the hospitals will nevertheless receive full reasonable cost for their service rendered Subscribers (determined by a court, if necessary) during the "cooling off" period—no profit, but yet no loss attributable to that business.

/s/ BRUCE TAYLOR

Bruce Taylor

(Oath and Jurat Omitted in Printing)

(title omitted in printing)

ANSWER OF DEFENDANTS BLUE CROSS OF GREATER PHILADELPHIA, ROBERT P. KANE, ATTORNEY GENERAL, AND THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA TO PLAINTIFFS' AMENDED COMPLAINT

1. The averment of paragraph 1 concerning the position of plaintiff Paul I. Guest is admitted. The defendants are without knowledge or information sufficient to form a belief as to the truth of the remaining averments of paragraph 1 and, therefore, deny the same. In any event, the averments of the last and third to last sentences of paragraph 1 state conclusions of law for which no answer is required.

2. The averments concerning the identity of the answering defendants Kane and the Insurance Department are admitted. The averments of the next to the last sentence of paragraph 2 concerning Blue Cross are denied as stated. The remaining averments of paragraph 2 state conclusions of law and, therefore, no answer is required.

3. The averments of paragraph 3 either state conclusions of law or merely explain the nature of the action and, therefore, no answer is required. Nevertheless, it is denied that the plaintiffs are entitled to either declaratory judgment or injunctive relief against any of the defendants.

4. The averments of paragraph 4 are denied insofar as they apply to defendant Blue Cross.

5. The averments of paragraph 5 state a conclusion of law and, therefore, no answer is required.

6. The averments of paragraph 6 state conclusions of law and, therefore, no answer is required. The Act speaks for itself.

7. The averments of paragraph 7 state conclusions of law and, therefore, no answer is required. The Act speaks for itself.

8. The averments of paragraph 8 insofar as they relate to Blue Cross or to any of its contracts are denied as stated. In any event, the contract referred to in paragraph 8 with respect to Blue Cross speaks for itself. The defendants are without knowledge or information sufficient to form a belief as to the truth of the remaining averments of paragraph 8 and, therefore, deny the same.

9. The averments of paragraph 9 are denied as stated. In any event, the averments of paragraph 9 state conclusions of law, and therefore, no answer is required. Furthermore, the contracts referred to therein speak for themselves.

10. The averments of paragraph 10 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 10 are denied.

COUNT I

11. Paragraphs 1 through 10 of this Answer are incorporated herein by reference.

12. The averments of paragraph 12 state conclusions of law and, therefore, no answer is required. The Act speaks for itself.

13. The averments of paragraph 13 state conclusions of law and, therefore, no answer is required. The contract referred to therein speaks for itself. Nevertheless, the averments of paragraph 13 are denied.

14. The averments of paragraph 14 state conclusions of law and refer to contracts which speak for themselves and, therefore, no answer is required. Furthermore, the defendant Blue Cross is without knowledge or information sufficient to form a belief as to the truth of the averments concerning the contracts referred to in paragraph 14 to which it is not a party and, therefore, denies same.

15. The averments of paragraph 15 state conclusions of law and, therefore, no answer is required. The contract referred to therein speaks for itself. Nevertheless, the averments of paragraph 15 are denied.

16. The averments of paragraph 16 state conclusions of law and, therefore, no answer is required. The contract referred to therein speaks for itself. Nevertheless, the averments of paragraph 16 are denied as stated.

17. The averments of paragraph 17 state conclusions of law and, therefore, no answer is required. The contract referred to therein speaks for itself. Nevertheless, the averments of paragraph 17 are denied as stated.

18. The averments of paragraph 18 are denied.

19. The averments of paragraph 19 are denied.

20. The averments of paragraph 20 are denied.

COUNT II

21. Paragraphs 1 through 10 of this Answer are incorporated herein by reference.

22. The defendants are without knowledge or information sufficient to form a belief as to the truth of the averments of the first sentence of paragraph 22 and, therefore, deny same. The averment of the second sentence

states a conclusion of law and, therefore, no answer is required. The Act speaks for itself.

23. The answer to paragraph 16 is incorporated herein by reference.

24. The averments of paragraph 24 are denied.

25. The answers to paragraphs 11 through 15, and 17 through 20 of the complaint are incorporated herein by reference.

26. The averments of paragraph 26 are denied.

COUNT III

27. Paragraphs 1 through 26 of this Answer are incorporated herein by reference.

28. The averments of paragraph 28 state conclusions of law and, therefore, no answer is required.

29. The averments of paragraph 29 state conclusions of law and, therefore, no answer is required. Nevertheless, they are denied.

30. The averments of paragraph 30 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 30 are denied.

31. The averments of paragraph 31 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 31 are denied.

32. The averments of paragraph 32 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 32 are denied.

33. The averments of paragraph 33 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 33 are denied.

COUNT IV

34. Paragraphs 1 through 33 of the Answer are incorporated herein by reference.

35. The averments of paragraph 35 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 35 are denied.

36. The averments of paragraph 36 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 36 are denied.

COUNT V

37. Paragraphs 1 through 26 of the Answer are incorporated herein by reference.

38. The letter referred to in paragraph 38 speaks for itself and, therefore, no answer is required.

39. The averments of paragraph 39 are denied as stated.

40. The notice published by the defendant Blue Cross speaks for itself, and is within the protection of Amendment I of the Constitution of the United States.

41. The answer to paragraph 30 of this Answer is incorporated herein by reference.

42. The correspondence referred to in paragraph 42 speaks for itself and, therefore, no answer is required. In any event, the averments are denied.

43. The averments of paragraph 43 are denied.

44. The averments of paragraph 44 are denied.

45. The answer of paragraph 32 of this Answer is incorporated herein by reference.

46. The averments of paragraph 46 are denied.

SEPARATE DEFENSES OF ALL DEFENDANTS FILING THIS ANSWER

1. The plaintiffs have withdrawn their request for temporary restraining orders.

2. The plaintiffs are not entitled to any injunctive relief, preliminary or permanent, against any of the defendants for, among other reasons, because the Act is constitutional.

3. The plaintiffs have failed to state a claim upon which relief can be granted with respect to the defendant Blue Cross.

4. The plaintiffs lack clean hands and have failed to do equity.

SEPARATE DEFENSES OF DEFENDANT ROBERT P. KANE, ATTORNEY GENERAL

5. The Attorney General does not intend to institute criminal proceedings under this Act so long as the constitutionality of the Act is undecided.

6. There is presently no case or controversy between the plaintiffs and the defendant.

SEPARATE DEFENSES OF DEFENDANT THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA

7. This suit is barred by Amendment XI to the Constitution of the United States.

8. There is presently no case or controversy between the plaintiffs and the defendant.

/s/ DENIS V. BRENAN

DENIS V. BRENAN

/s/ WILLIAM E. ZEITER

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/s/ HOWARD M. HOLMES

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Attorney for Defendants
Robert P. Kane, Attorney General
The Insurance Department of the
Commonwealth of Pennsylvania

(Certificate of Service Omitted)

SUPPLEMENTAL AFFIDAVIT

PAUL I. GUEST, being duly sworn according to law deposes and says:

1. That he is a plaintiff in this case, a member of the Bar of this Court, the Chairman of the Delaware Valley Hospital Council ("DVHC"), and the President of Methodist Hospital, also a plaintiff in this action; that he is one of two negotiators representing the Delaware Valley Hospital Council in negotiations with Blue Cross of Greater Philadelphia; that he makes the following statement which is based upon his own personal knowledge in reply to certain allegations contained in the Affidavits of Bruce Taylor, President of Blue Cross:

2. In Paragraph 26 of Mr. Taylor's Affidavit, he indicates that upon assuming the office of the Insurance Commissioner, William Shephard issued a news release (attached thereto at Exhibit 16), advising that the control measures previously mandated would be continued. While it is true that Commissioner Shephard originally issued the release, he, on behalf of the Insurance Department and Governor Shapp subsequently changed this position on the so called "ceiling" and "plus factor" immediately after February 14, 1975, when Governor Shapp and Senator Schweiker met with the Hospital and Blue Cross representative and trustees of many of the hospitals involved.

3. Subsequent to this meeting, representatives of the Governor—primarily, Commissioner Shephard, Gerald Mongelli, Deputy Insurance Commissioner, and Robert Archer of the Insurance Department—sought to mediate the contract dispute between the hospitals and Blue Cross. Archer, Mongelli, and Shephard met numerous times with

representatives of Blue Cross and the Hospitals. In these meetings, the Insurance Commissioner indicated that the Department's position had changed and that the Department would approve a contract without a ceiling and one including a "plus factor" which was urged as necessary to help the hospitals alleviate some of the substantial losses resulting from unreimbursed patient care and unfunded operating growth need.

4. The idea of a "plus factor" in the nature of a percentage of allowable costs is not a novel provision in Blue Cross contracts. The Agreement between Blue Cross and the Hospitals dated July 1, 1967 (attached to the original Taylor affidavit at Exhibit 13), contained, *inter alia*, the following principles:

"1-10 Allowance in Lieu of Specific Recognition of Other Costs

Principle

"In lieu of specific recognition of other costs in providing and improving services, an allowance amounting to two (2) percent of allowable costs (with the exception of interest expense and the allowance under this principle) is includable as an element of reasonable cost of Covered Services.

Application

"Difficulty in measurement, lack of adequate data and other considerations have precluded specific recognition of various elements which are germane to costs of Covered Services for Subscribers. Moreover, although the methods to be utilized by Providers for determining the actual cost of Covered Services provided to Subscribers are the best available, there is some lack of precision in methods for determining

costs at the present stage of development of cost finding which represents a contingency for which recognition is appropriate. It is the established practice of a significant number of large third-party purchasers to include in payment for costs of services a factor in the form of an allowance to cover various elements not specifically recognized or not precisely measured.

"1-11 Allotment for Development Requirements Principle

"In partial recognition of the financial needs of the Provider for certain developmental expenses which have not been provided for under these Principles of Reimbursement for Provider Cost, an allotment amounting to one (1) percent of allowable cost (with the exception of interest expense and the allotment under this principal) is included as an element of reasonable cost of Covered Services.

Application

"The amount of reimbursement received by the Provider under this allotment shall be used by the Provider for the sole purpose of meeting cost which may be incurred by the Provider for purchasing equipment (Types I and II Hill-Harris) for the improvement or maintenance of patient care standards. Any amount which is not used for this purpose during the course of the year shall be available for such use in subsequent years."

Principles 1-10 and 1-11 were both deleted by the Amendments to the 1967 agreements which were effected July 1, 1970, and which added in lieu of these principles incentive payments for use of inpatient provider facilities, cost containment, and cost reduction projects.

The agreement of July 1, 1971, negotiated after the forced termination of the 1967 agreement as modified in 1970, resulted in the elimination of all incentive payments.

5. Meetings continued through July with the Insurance Department and eventually with the Governor and other members of his staff and cabinet; throughout these meetings, the inclusion of a "plus factor" was presumed, and the primary issue was how much the "plus factor" would be. Finally, in all-day meetings with the Governor and his representatives on August 2nd and 3rd, 1975, all the basic issues were resolved, except the amount of the "plus factor". The so called "quality control standards" were all resolved. However, when agreement could not be reached on the amount of the "plus factor," Governor Shapp signed Act 94 and the meetings were discontinued. As a result of Act 94, no negotiations are now taking place.

6. On August 8, 1975, at a meeting arranged by Insurance Commissioner Shephard to discuss the implementation of Act 94, the Blue Cross officials, Bruce Taylor, President, and Jerome Lynch, Executive Vice President, refused to discuss the Implementation of Act 94 claiming they did not know the meeting had been called for that purpose and walked out.

7. Immediately following the "walk out", the DVHC negotiators and the attorney for Blue Cross, through the efforts of and in the presence of Mr. Mongelli, Deputy Insurance Commissioner, reached complete agreement on a package settlement which was acceptable to the Insurance Department and which they agreed to recommend to their respective clients.

8. The proposed agreement which was approved by the Insurance Department contained a "plus factor". It was presented to the hospitals by their negotiators and

was accepted. The Blue Cross Board of Directors rejected it.

Contrary to the statements of Mr. Taylor in paragraph 44, the reason no agreement was reached was not that the "DVHC negotiators steadfastly insisted upon a profit percentage and abandonment of quality controls as the price of a contract." Blus Cross, the Hospitals and the Insurance Department had agreed upon the "quality control standards." Agreement was not reached because the Blue Cross Board would not agree to the amount of the "plus factor" which was acceptable to the Hospitals and the Insurance Department. Blue Cross had already agreed to the principle of a "plus factor" or what Blue Cross now refers to as a "profit percentage"; it was only that Blue Cross would not agree to the "price."

9. Exhibit 33 to the original Taylor affidavit is a letter from Frank H. Abbott, attorney for DVHC, to Commissioner Shephard dated July 8, 1975, which represents the Hospitals' position as of July 3, 1975, after we first met with the Governor. It was prepared at the Governor's request so that he would have a statement of the remaining issues. [Even though Governor Shapp had requested both parties to put in writing the remaining issues and to state their positions on each of them, to my knowledge Blue Cross did not submit in writing a copy of its position.] The Hospitals subsequently agreed to a reduction of the 7½% figure referred to for unreimbursed patient care and operating growth need. The agreement which was recommended by the attorneys for Blue Cross and the Hospitals, approved by the Insurance Department on August 8, 1975 and accepted by the Hospitals, contained a figure of 4% per year for each of three years, plus one percent considered to be interest on funds withheld during the contract dispute. The "pot" was to be distributed

among the hospitals based upon their unreimbursed patient care and operating growth needs. It was not to be a flat payment of 4% to each hospital. This agreement was rejected by the Board of Directors of Blue Cross.

10. Contrary to the implication in paragraphs 34 and 35 of Mr. Taylor's Affidavit, the Delaware Valley Hospital Council did not refuse to accept a contract negotiated by the proprietary hospitals, but on the contrary offered to accept the contract if it contained *all* of the provisions in the proprietary hospital agreement, *i.e.* those dealing with reimbursement as well as the cost containment measures. Blue Cross at all times refused to offer the entire proprietary hospital agreement to the non-profit hospitals.

11. Contrary to the statement in paragraph 40 of Mr. Taylor's Affidavit, the Philadelphia medical school hospitals did not "abandon the DVHC position." The Medical School Hospitals remained in the Delaware Valley Hospital Council, but negotiated and executed a separate agreement with Blue Cross principally because of governmental pressure in the form of threats to cut off their state subsidies which far exceed the loss they would sustain under any Blue Cross contract. The Medical School agreement contains a provision which will give the Medical School Hospitals the benefit of any "better" contract negotiated by the Non-Medical School Hospitals with Blue Cross, and this is the main reason the Blue Cross Board did not accept the agreement recommended by its attorney and the Insurance Department: the Medical Schools—whose daily rate is more than 50% higher than that of the other DVHC hospitals—would have received the same 4% "plus factor."

12. In paragraph 53 of his affidavit, Mr. Taylor argues that contractual or regulatory controls are necessary to curb soaring hospital costs, necessarily implying

that there is no legitimate reason for these cost increases. However, in pressing for a rate increase at the Insurance Department Public Hearing on March 17, 1971, Mr. Taylor made a statement from which the following quotation is taken:

> "If the protection of public interest is to be expanded, then it must be through the establishment of specific involuntary controls over the costs which a hospital incurs. Before discussing any such changes, however, one fact should be recognized. The overwhelming cause of rising hospital per diem costs in the past five years has been the increases in the pay scale of hospital employees. As we have said on prior occasions, hospital employees were substantially underpaid and much of this increase has been necessary to bring them to a level comparable to other members of our nation's working force. The extent to which hospital employees receive further wage increases beyond the level now existing is a matter for hospital management and labor negotiations. Blue Cross is not a participant in that collective bargaining operation and has no legal authority to make itself a party. Moreover, we have no expertise on the wages of hospital employees."

13. In that same statement to the Insurance Department Mr. Taylor also argued persuasively against the position which Blue Cross now advances that Act 94 is justified as rate-making legislation which, in effect, delegates the setting of rates to the Blue Cross organization. I again quote from Mr. Taylor's statement of March 17, 1971:

> "• • • Before discussing the implementation of these various possibilities by Blue Cross, certain general considerations need to be recognized, however.

> "First, these changes are unlikely to be wrought through voluntary changes in the Blue Cross-Hospital contract. Our past experience makes it clear that hospitals simply won't agree to such changes on a voluntary basis. To inflict such terms on the hospitals will remove many of them as providers under our contracts. As a result our subscribers will be restricted to non-member indemnity benefits; a serious burden on them.
>
> "Second, Blue Cross regulation of hospital cost raises serious internal problems. Hospitals vary infinitely and general standards applicable to all cannot be fixed fairly. Differences in plant, in types of cases, types of medical practice and many other facts affect their cost. To consider these multiple factors properly would require a major expansion of the Blue Cross staff. Moreover, Blue Cross, even with an expanded staff, is not peculiarly fit for this decisional process. It has no expertise in many of these areas. Moreover, as the payor, Blue Cross decisions could be biased by its interest in reducing its own payments.
>
> "Third, decisions on most areas of hospital cost control will have profound influences on the entire health care delivery system. To suggest that such decisions should be exclusively in the hands of a single purchaser of health care is clearly foolhardy. Blue Cross personnel can claim no infallibilty in this field, nor even special training, where medical practice and hospital procedures are involved. Obviously and without false modesty this role should not be exclusively ours.
>
> "Fourth, legal authority is required to produce involuntary changes in the health care system as it exists today. The changes must be made uniformly in

all hospitals and among the entire medical profession; they must be backed by the financial efforts of the community; and they must have the support of the public in their capacity as patients as well as subscribers to Blue Cross. Such uniformity can only come through governmental supervision based on law, not the indirect pressure of changing Insurance Commissioners through a variety of Blue Cross entities.

"Finally, it must be recognized that Blue Cross is not the only payor in the health care field and whatever it may recommend cannot possibly prevail if Medicare and Medicaid follow other practices. To date neither the state nor the federal government has shown any capacity to provide realistic control of hospital costs.

"So much for general principles."

14. In support of the Motion for Summary Judgment of Plaintiffs and Plaintiffs-Intervenors, we originally submitted the affidavit of Mr. Edward Armstrong, the Administrator of Jeanes Hospital, to substantiate the fact that even as applied to a hospital with a relatively small indigent patient population and one which had experienced no unusual problems under its contract with Blue Cross, the effect of Act 94 would be to impose upon that hospital a loss of more than $50,000 a year. (Affidavit of Edward J. Armstrong, paragraph 10).

Nowhere in Mr. Taylor's Supplemental Affidavit is it disputed that there are costs incurred by Jeanes and the other hospitals which are simply not reimbursed by Blue Cross. Instead the affidavit details other sources of income available to Jeanes which can be used to offset the amount by which Blue Cross fails to reimburse the hospital its actual costs of providing service. While the legal distinction between stealing from a rich man and stealing from a poor one is not readily apparent, we are submitting herewith additional Supplemental Affidavits to document the fact, seemingly conceded by Blue Cross, that Jeanes Hospital is among the most financially secure members of plaintiff hospital class.

/s/ PAUL I. GUEST

Paul I. Guest

(Oath and Jurat Omitted in Printing)

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF PHILADELPHIA } *ss:*

JOSEPH A. WILLIAMSON, being duly sworn according to law, deposes and says the following based on his personal knowledge thereof:

1. That he is the President of the Delaware Valley Hospital Council ("DVHC"), plaintiff-intervenor in this case, a non-profit association of sixty-seven non-profit hospitals in Southeast Pennsylvania, located at 311 South Juniper Street, Philadelphia, Pennsylvania 19107. DVHC was and is the bargaining representative of those members of plaintiff hospital class which are signatories to the Delaware Valley Agreement, as it is denominated in the Complaint, in their contract negotiations with Blue Cross.

2. That in this position which he has held for two years, he is required to be knowledgeable about the terms and usage of the Delaware Valley Agreement, its affect generally on the hospitals to which it applies, and its affect on individual hospitals in the context of each hospital's unique patient population and financial situation. The impact of the Delaware Valley Agreement on selected hospitals is reflected in the affidavits attached hereto as exhibits.

3. That under the Principles of Reimbursement contained in the Delaware Valley Agreement, Blue Cross does not recognize and will not reimburse the hospitals certain expenses although it is clear that these are expenses incurred regularly as a necessary part of the hospitals' performance of their duties to the public. Chief among these expenses which Blue Cross will not "allow" are the

costs of unreimbursed patient care, which includes treatment of indigents, charity allowances, and bad debts as detailed below.

4. That while Blue Cross does undertake to pay bad debts resulting from its subscribers' failure to pay the relatively small deductible or co-pay amounts specified in their subscriber contracts, it assumes no responsibility for bad debts incurred by its subscribers once their coverage has expired. Thus, a substantial portion of the hospitals' costs of covering bad debts—no part of which is borne by Blue Cross—is attributable to costs expended in treating patients who entered the hospital as Blue Cross subscribers, but who continued to receive services after their coverage had expired, charges for which proved uncollectible. In calculating the pro rata share of costs of unreimbursed patient care which ought to be borne by Blue Cross, the hospitals represented by the attached affidavits may not have made consistent adjustments for payments by Blue Cross to reimburse subscriber defaults in paying deductible or co-pay amounts. However, in no case would such an adjustment materially alter the magnitude of Blue Cross' underpayments to the hospitals.

5. That there is no hospital which did not suffer operating losses under the Delaware Valley Agreement—and will not now suffer losses if Act 94 is effective to reinstate that Agreement—as a result of Blue Cross' failure to pay on behalf of its members, in common with all other private paying patients, a share of the hospital's costs of unreimbursed patient care in the same proportion which Blue Cross covered charges bear to total charges entered by the hospital against its patients.

6. That the amount of money properly allocable to Blue Cross subscribers, but which Blue Cross will not reimburse the hospitals under the Delaware Valley Agree-

ment, varies according to each hospital's individual patient mix. Where the indigent patient population is relatively small as at Jeanes Hospital, the extent of this loss can be as small as $50,000 a year (Affidavit of Edward J. Armstrong, paragraph 10). On the other hand, hospitals which must expend far greater amounts in providing unreimbursed patient care suffer proportionally greater losses as a result of the limitations in the Blue Cross payment formula. If Blue Cross paid its full share of hospital costs, Mercy Catholic Medical Center ("MCMC") would have received an additional $655,624 from Blue Cross for fiscal year 1974 (Affidavit of Ragnar W. Anderson attached hereto as Exhibit "B", paragraph 6); in the same year, Blue Cross would have paid Presbyterian—University of Pennsylvania Medical Center ("PUPMC") an additional $203,400 (Affidavit of Carl L. Mosher attached hereto as Exhibit "C", paragraph 6); for fiscal year 1975, the amount representing Blue Cross underpayment to Episcopal Hospital is $337,235 (Affidavit of Fred G. Clark, attached hereto as Exhibit "A", paragraph 7).

7. That for a non-profit hospital, this loss necessarily translates into net operating loss except to the extent that the hospital can surcharge patients who are self-insured or covered by commercial insurers and thus reduce the loss represented by that share of unreimbursed costs of patient care which is not paid by Blue Cross and other third party payers. While in most cases it is not possible to impose so large a financial burden on a relatively small segment of the patient population (Exhibit A, paragraph 8), the need to reduce losses by surcharging private paying patients has resulted in situations where private insurers, which normally pay full charges, are paying 40% more than Blue Cross for comparable services (Exhibit B, paragraph 7).

8. That while some hospitals have available unrestricted endowment fund income which can be applied to reduce the hospital's net operating loss, others do not have such other sources of income (Exhibit B, paragraph 10). Even where such income is available, it is often inadequate to offset operating losses (Exhibit A, paragraph 9; Exhibit C, paragraph 7).

9. That in the case of Episcopal Hospital, it was necessary in fiscal years 1974 and 1975, and is again necessary in 1976, to cut into endowment fund principal to the extent permitted by the law governing non-profit corporations in order partially to reduce net losses. Episcopal Hospital was required to reduce its endowment fund principal by close to $1,000,000 in these three years alone (Exhibit A, paragraph 10).

10. That to the extent that endowment fund income is simply not available or is inadequate to balance operating losses resulting from unreimbursed patient care, the hospitals must utilize money which ought properly to be funded from depreciation allowances on patient charges. In order to show a break even figure on operating expenses for fiscal year 1975, Episcopal Hospital would have had to use its entire depreciation reserve for that year had it not chosen instead to dip into its endowment fund principal; even after borrowing from the principal, Episcopal still depleted nearly two-thirds of its depreciation reserve to make up operating losses. (Exhibit A, paragraph 11). In fiscal year 1974, MCMC used virtually all of its depreciation reserve to meet its operating needs (Exhibit B, paragraph 9).

11. That the hospitals' shortage of working capital resulting from the failure of Blue Cross to reimburse the hospitals their share of the costs of unreimbursed patient care is exacerbated by the delay suffered by the

hospitals in receiving payments from Blue Cross. While Mr. Taylor suggests that this problem is obviated by Blue Cross' provision of an advance equal to 15 days of current costs and its willingness to provide an additional 15 day advance on which interest is charged (Supplemental Affidavit of Bruce Taylor, paragraph 70), in many cases, the actual time lag experienced by the hospitals between time of billing and receipt of payment far exceeds 15 days. Thus, MCMC regularly experiences average delays in payment of more than 40 days or the equivalent of half a million dollars more than is contemplated by the 15 day advance program (Exhibit B, paragraph 8).

12. That in addition to "normal" delays in receipt of Blue Cross payments, whenever there is a dispute between a hospital and Blue Cross as to the amount of reimbursable costs, it is the hospital which pays the cost of the delay and may ultimately be forced to compromise a legitimate claim because it can not afford to defer payment indefinitely and still continue to operate. PUPMC, for example was forced to accept payment from Blue Cross for fiscal year 1970 of only 61% of its allowable costs. It did so finally in January of 1973, in order to recover at least some part of the close to one million dollars in challenged costs for that year and fiscal year 1971 which Blue Cross was holding back. The hospital received no interest whatsoever on this money. (Exhibit C, paragraph 9).

13. That, as a result of the inadequacy of Blue Cross formula reimbursement and the delays imposed by Blue Cross on the hospitals in receiving payments, some hospitals are required to borrow money simply in order to meet their operating expenses (Exhibit C, paragraph 10).

14. That in those cases where short term borrowing is avoided by a hospital's use of depreciation reserves to

meet current operating expenses, the need to borrow money to continue operations is simply pushed forward to the time when the hospital has to replace its plant or equipment and lacks the reserve which would otherwise be available for that purpose. (Exhibit B, paragraph 9).

15. That, in addition to the fact that the depreciation factor which is recognized by Blue Cross must, in practical effect, be used by the hospitals to make up unreimbursed costs which Blue Cross does not recognize, the Blue Cross reimbursement formula under the Delaware Valley Agreement does not make any provision for the hospitals' operating growth needs. This is in contradistinction to the fact that Blue Cross contracts with hospitals in other states do include a so-called plus factor to provide for needed expansion or improvement of the hospitals' plants and equipment; that such a plus factor was included in the 1967 contract between Blue Cross and the hospitals represented by DVHC; that the Insurance Department and the Governor recommended the inclusion of a plus factor in attempting to mediate the contract dispute between the hospitals and Blue Cross; and that a contract negotiated by the attorneys for the hospitals and Blue Cross, approved by the Insurance Department, accepted by the hospitals, but rejected by Blue Cross, included such a plus factor.

16. That, in order to meet their operating expenses in spite of the fact that, under the Delaware Valley Agreement, Blue Cross simply does not pay its full share of these expenses, the hospitals are being forced to use funds intended and ultimately needed for other expenses less immediate perhaps, but no less necessary to the hospitals' continued financial viability over time.

17. That if all its patient charges were reimbursed on the same basis as those of Blue Cross subscribers, there

is no hospital which would not in time be threatened with insolvency.

The foregoing is true and correct to the best of my personal knowledge.

/s/ JOSEPH A. WILLIAMSON
Joseph A. Williamson

(Oath and Jurat Omitted in Printing)

SUPPLEMENTAL AFFIDAVIT OF BRUCE TAYLOR PRESIDENT OF BLUE CROSS OF GREATER PHILADELPHIA

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF PHILADELPHIA *ss:*

BRUCE TAYLOR, being duly sworn according to law, deposes and says that he is President of Blue Cross of Greater Philadelphia, one of the defendants in the foregoing action; that as such he is duly authorized to, and does make this supplemental affidavit on its behalf; that he makes this supplemental affidavit and made the affidavit dated October 7, 1975 which was previously filed of record in this action on personal knowledge; and that the facts set forth in this supplemental affidavit and in his affidavit dated October 7, 1975, are true and correct. Further, deponent says in reply to the Affidavit of Edward J. Armstrong, Administrator of Jeanes Hospital, dated October 6, 1975, that:

59. The reimbursement paid Jeanes Hospital, as well as every other Pennsylvania non-profit hospital which contracted with Blue Cross of Greater Philadelphia under the 1967, 1971 and 1973 Agreements was based on the same cost accounting principles as utilized by the federal government in computing Medicare payments. These procedures, which were outlined in my October 7, 1975 Affidavit (See ¶ 24), require that all legitimate costs associated with the treatment of Subscribers be paid by the Plan. These costs include not only payroll, medicine, supplies and meals, but also encompass maintenance expenses, depreciation, and interest on borrowed funds. Exhibit A to the 1971 Agreement details these various costs and incor-

porates by reference the appropriate Medicare rules, regulations and interpretations which provide the detail procedures utilized by independent certified public accountants in fixing final payments.

60. The Medicare program is based on the principle that the costs attributable to a given patient should be borne by that patient or the third-party payor responsible for reimbursing the hospital for services rendered that patient. In developing the extensive procedures necessary to accomplish this result, Congress, and the Social Security Administration, borrowed substantially from the "Principles of Payment for Hospital Care" (the "AHA Principles") approved by the American Hospital Association ("AHA") in September, 1953, a copy of which document is attached as Exhibit 35. Jeanes Hospital and the other hospital parties to the 1967 and 1971 Agreements are members of the American Hospital Association.

61. Although Mr. Armstrong suggests in Paragraph 6 of his Affidavit that the Plan should bear the costs attributable to "providing care to indigents", "uncollectible amounts other than those of Blue Cross subscribers, providing charity allowances" and underwriting all "educational and research activities", the AHA Principles state such is improper. Indeed, an analysis of the comparable sections of Exhibit A to the 1971 Agreement and the AHA Principles shows substantial identity. (*e.g.*, bad debts, charity and courtesy allowances—Agreement § 1.3, Principles § 2.304; educational activities—Agreement § 1.4, Principles § 2.302; and research—Agreement § 1.5, Principles § 2.301).

62. The ceiling on payments which was negotiated into the 1971 Agreement for fiscal years 1972 and 1973 was not an idea novel to the Plan. The AHA Principles specifically provide in Section 3.400 that, "Ceilings on the

amount of payment are not inconsistent with the principle of 'full costs' and may be established through conference between third-party agencies and contracting hospitals."

63. As a non-profit charitable institution, Jeanes Hospital, as well as all other hospitals represented by the DVHC, receives substantial charitable contributions and endowment income. These monies, to the extent they are not designated by the donor for specific operating expenses, are *not* deducted from the cost of running the hospital by the Plan or Medicare in determining reimbursable costs. (See, § 1.6 of Exhibit A, 1971 Agreement).

64. The certified financial statements prepared for Jeanes Hospital by its certified public accountants, Coopers & Lybrand, show that it realized $514,000 in 1973, and $454,000 in 1974 from investments and contributions. Indeed, when this amount was added to operating expenses, Jeanes Hospital realized net operating profit in 1973 of $303,560, and $284,945 in 1974. A copy of these financial statements is attached as Exhibit 36.

65. In addition to realizing substantial current income from endowments and contributions, Jeanes Hospital has a substantial investment portfolio which provides a steady income stream. As of June 30, 1974, the cost of this investment fund amounted to more than $1 million. Further, note 4 to the financial statements suggests that the continuing endowment income of which Jeanes Hospital is the beneficiary, permits it to obtain low cost loans. Importantly, any interest paid on such loans is recognized as a reimbursable cost by the Plan. Lastly, it should be noted that although the main building of Jeanes Hospital was contributed property, the Plan has paid depreciation on this plant thereby paying the Hospital for something which it never really purchased.

66. The state program of medical assistance for the poor, known as "Medicaid", provides a mechanism whereby hospitals may be reimbursed for medical services rendered indigent persons. Under this program, a hospital contracts with the Pennsylvania Department of Public Welfare on a cost basis which is similar to that utilized by the Plan and Medicare. However, Jeanes Hospital has historically disavowed involvement in such programs. An article published in the Evening Bulletin on September 29, 1961 quotes Mr. Manley C. Solheim, then Administrator of Jeanes Hospital, as stating its "Board of Directors does not believe in government subsidy." A copy of this article is attached as Exhibit 37. Further, a review of the most current listing published by the Pennsylvania Department of Public Welfare of hospitals participating in Medicaid indicates that Jeanes Hospital is not included in that program. A copy of this list is attached hereto as Exhibit 38. Thus, although Jeanes Hospital may be complimented for its steadfast refusal to accept government subsidies or payments intended to defray the cost of providing medical services to indigent persons, it is difficult to understand why, on the other hand, it desires to collect such a subsidy from the Blue Cross Subscribers.

67. Other hospitals, not as well supported as Jeanes Hospital or committed to a policy of non-government affiliation have actively participated in the Medicaid program. Based on a review of the listing attached as Exhibit 38, it appears that all of the other DVHC represented hospitals receive Medicaid payments.

68. In addition to the Medicaid program, a considerable number of hospitals receive substantial financial aid under the Hill Burton Act (42 U.S.C. § 291 *et seq.*) This legislation permits the Federal government to make monies available to hospitals for construction purposes.

As with any other contributed funds, although these are given directly by the taxpayers, the full cost of capital projects financed under Hill Burton are entitled to depreciation allowances over their useful life and such is a reimbursable cost.

69. Although hospital charges in the Greater Philadelphia area generally run about 20% over the cost of such care as reimbursed by the Plan and government third party payors under Medicare and Medicaid these payments do include factors significantly beyond a strict "barebones" cost. Further, of the three payments, the Blue Cross reimbursement is the highest, and based on recent changes in Medicare, the incremental difference will soon widen.

70. The 1973 Agreement contained an extensive procedure to ensure that all contracting hospitals are paid on a current basis. Under that accord, each hospital receives an advance equal to 15 days of current costs, and if it so requests, the Plan will make a further 15 day advance, although interest is charged on the second increment. Further, all hospitals are paid currently for Subscriber care utilizing a per diem rate calculated from the hospital's own budget. These per diem rates are adjusted quarterly utilizing the hospital's actual cost experience and at the end of each year are settled based upon a final audit conducted by independent certified public accountants to determine if there is any overage or underage in the payments. Thus, the hospital's working capital requirements due to the Blue Cross business are insignificant, if at all.

71. Since all hospitals which were parties to the 1973 Agreement are being paid currently under the procedure described in the foregoing paragraph, the enactment of Public Act No. 94 should have had no adverse affect upon

their financial integrity. Indeed, since Jeanes Hospital, as well as the other DVHC represented hospitals, have accepted retroactive payments in the past, the current situation is not substantially different. A copy of the signature page of the Jeanes Hospital 1971 Hospital Agreement indicating it was signed on May 15, 1972, although effective July 1, 1971, is attached hereto as Exhibit 39.

72. Paragraph 7 of Mr. Armstrong's affidavit states that "Blue Cross has directed Jeanes Hospital that unless it is willing to negotiate a new payment ceiling, *i.e.*, a percentage limitation over allowable costs for the previous year, it will be reimbursed in accordance with the ceiling limitation contained in a 1974 Agreement negotiated by Blue Cross with entirely different parties." In support of this baseless assertion, Mr. Armstrong refers to a letter dated September 19, 1975 addressed to Episcopal Hospital which is attached as Exhibit C to the Memorandum of Plaintiffs and Plaintiff's Intervenors in Support of Motion for Summary Judgment. (Subsequently copies of a substantially similar letter were forwarded to all DVHC represented hospitals under date of September 23, 1975.) The letter does not refer to final rates or the total reimbursement which the hospital will receive. Rather, since Public Act No. 94 reinstates the 1971 Agreement a limitation on interim rates is required. This matter was discussed at length between attorneys for the Plan and the DVHC hospitals. Indeed, in a letter addressed to Blue Cross counsel under date of September 26, 1975, Frank H. Abbott, Esquire, the DVHC solicitor, forwarded for comment a letter dated September 25, 1975 addressed to all DVHC represented hospitals wherein he advised them that the information requested in the Plan's letter of September 23, 1975 would have "no affect on final settlement". A copy of these letters is attached as Exhibit 40.

73. By letter dated October 6, 1975 from Dr. Howard W. Baker, Plan Vice President, to the Chief Executive Officer of each DVHC represented hospital, the Plan explicitly stated that the September 23, 1975 letter was intended to deal only with the establishment of interim rates and not affect final settlements which would be based on "full reasonable costs which, of course, as determined by the circumstances, might be greater or less than the interim rates." A copy of this letter is included with Exhibit 40.

74. A schedule setting forth the amount of the advances made by the Plan to the various DVHC represented hospitals is attached as Exhibit 41.

/s/ BRUCE TAYLOR

Bruce Taylor

(Oath and Jurat Omitted in Printing)

SECOND SUPPLEMENTAL AFFIDAVIT OF BRUCE TAYLOR PRESIDENT OF BLUE CROSS OF GREATER PHILADELPHIA

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF PHILADELPHIA } *ss:*

BRUCE TAYLOR, being duly sworn according to law, deposes and says that he is the President of Blue Cross of Greater Philadelphia, one of the defendants in the foregoing action; that as such he is duly authorized to, and does make this Affidavit on its behalf based on his personal knowledge; and that such statements are true and correct. Further, deponent says in reply to the Affidavits of Paul I. Guest, Chairman of the Delaware Valley Hospital Council and President of Methodist Hospital ("Guest Affidavit"), Joseph A. Williamson, President of the Delaware Valley Hospital Council ("Williamson Affidavit"), Fred G. Clark, Vice-President of Finance, Episcopal Hospital ("Clark Affidavit"), Ragnar W. Anderson, Acting Director of Fiscal Affairs and Controller of Mercy Catholic Medical Center, Fitzgerald Mercy Division ("Anderson Affidavit"), and Carl L. Mosher, President of Presbyterian-University of Pennsylvania Medical Center ("Mosher Affidavit"), that:

75. The Guest Affidavit contains a lengthy description of the negotiations between the DVHC represented hospitals and the Plan which is, in many respects, at variance with my recollection and understanding of those events and the positions of the various individuals and parties identified. However, as I believe the specifics of the negotiations are neither relevant nor material to the instant litigation, I have refrained from a seriatim response, but will in the following few paragraphs seek to clarify

certain factual matters upon which there can be no dispute.

76. Although the negotiations between the Plan and DVHC represented hospitals included discussions with regard to the feasibility of a "profit factor", such was always considered in the context of a settlement package which would necessarily include effective quality controls designed to preclude unnecessary services, facilities, or utilization which inflate hospital costs without improving patient care. Indeed, in the Insurance Department's Order and Adjudication at Docket No. R-75-9-22, dated October 16, 1975, with regard to the Plan's last rate filing, the Commissioner stated, "The Department is hopeful that a viable agreement will be reached [with the DVHC represented hospitals] in the reasonably immediate future which will encompass, among other things, appropriate methods of cost control and utilization review." Clearly, cost and quality controls have, and continue to be, a major concern of the Pennsylvania Insurance Department, the state regulatory agency which must approve any Blue Cross-Hospital contract. A copy of the referenced portion of the Order is attached as Exhibit 42.

77. Paragraph 4 of the Guest Affidavit cites Principle 1-10 of the 1967 Agreement as an example of a "plus factor" which appeared in previous Blue Cross-Hospital accords. Unfortunately, the affiant does not explain the reason for the elimination of this provision which was originally copied verbatim into the 1967 Agreement from the then existing Medicare Regulations. At the initiation of the Medicare program, the U.S. Department of Health, Education and Welfare (HEW) believed the untried nature of the cost finding methodology might preclude or fail to pick up certain true patient care costs, hence the special allowance and allotment. However, this fear proved unfounded, and HEW amended the Medicare

Regulations (20 C.F.R. § 405.428) on June 27, 1969 to eliminate, as an element of reasonable cost, the allowance in lieu of specific recognition of other costs that had been afforded by Principle 1-10. Following this change, the 1967 Agreement, with the acquiescence of all contracting hospitals, was amended to reflect this change in Medicare Regulations.

78. The Guest Affidavit alleges in paragraph 11 that considerable governmental pressure was exerted on the medical school hospitals to force their abandonment of the DVHC position. This assertion is clearly at odds with the hospitals' own published statement attached as Exhibit 24 to my prior Affidavit. Further, since Mr. Guest fails to provide any supporting evidence for his allegation, it would seem improper for inclusion in what purports to be a factual affidavit. Moreover, the Guest Affidavit fails to reflect the fact that the 1974 Agreement was negotiated with, and executed by, not only all the medical school hospitals in Philadelphia, but also a number of community hospitals which were and are members of the DVHC. A listing of the several hospitals which have executed the 1974 Agreement is attached as Exhibit 43.

79. The sections of my testimony before the Insurance Department on March 17, 1971 which are quoted in paragraphs 12 and 13 of the Guest Affidavit are obviously taken from the context of my full presentation and therefore are somewhat misleading. In order to cure this deficiency there is attached hereto as Exhibit 44, a complete copy of the transcript made at those hearngs, which includes the full text of my remarks.

80. In reviewing Exhibit 44 it should be clear that while there are numerous costs over which a hospital has little, if any control, there are also many areas where considerable cost savings could be achieved and patient care upgraded by the initiation of more efficient methods.

Since, as I previously testified, many of these areas involve the relationships between hospitals as a group, as well as the willingness of individual institutions to abandon old methods, success would be more predictable through direct regulation than via contract negotiations. Initially it appeared my apprehension was well founded as the negotiations preliminary to the final approval of the 1971 Agreement were often marked by little progress and heated exchanges. However, the final product of that bargaining was a contract which realized many, if not most of the goals I described in my testimony as needed reforms in the health care delivery system and which were incorporated into the Guidelines published by the Insurance Department. (See, Exhibit 15). For example, at pages 45-48 of the transcript, I urged greater control over medical education costs. (Guideline No. 3) In response, Section 1.4 of Exhibit A to the 1971 Agreement imposes certain limitations on these costs for purposes of Blue Cross reimbursement. At pages 43-45 and 52-54 of the transcript, I argued for licensing legislation which would require approval of new capital projects and expansions of services, as well as recertification of existing services and facilities. (Guidelines 1 and 2) Section 24 of the 1971 Agreement achieves essentially the same result through employment of an independent private planning agency, the Hospital Survey Committee ("HSC"), which reviews any request for expansion, while periodically reviewing all existing facilties to ensure they conform with current safety standards and such are indeed necessary. In the event HSC makes an adverse findng as to either the need for a new or existing service or facility, the 1971 Agreement provides no depreciation or interest expense with respect to such will be reimbursed by the Plan. Similarly, my comments with regard to staffing patterns, page 48-50 (Guideline 4), depreciation, pages 50-52 (Guideline 5 and 35) and length of stay, page 56 (Guidelines 18, 19, 23 and

34) have found expression in the 1971 Agreement as well as a substantial majority of the items identified in the Insurance Department's Guidelines.

81. The indirect form of regulation achievable through contractual arrangements which are reviewable by a state agency, but not capable of direct imposition may be blunted by a breakdown in negotiations between the private contracting parties. In such cases the stimulus of compulsory mediation, such as that required by Act No. 94, is often helpful. Clearly this was the solution selected by the Pennsylvania General Assembly when it passed House Bill 1347.

82. Prior to signing this bill into law, Governor Shapp personally acquainted himself fully with the negotiations between the Plan and the DVHC represented hospitals. Paragraph 5 of the Guest Affidavit describes his involvement and unequivocally admits that the Governor signed Act No. 94 only after it was clear to him that no immediate resolution to the negotiating impasse was near and action was required to protect the public interest.

83. The Williamson Affidavit suffers from many of the same infirmities which characterized the Guest Affidavit and are fully answered in the accompanying affidavit of Mr. Lynch, the Plan's Executive Vice-President. However, I would note that Mr. Williamson makes an interesting admission in his Affidavit when he concedes the Plan pays the full cost of the covered medical services rendered its Subscribers, but argues this is not enough for the Plan should also subsidize hospitals for those patients from whom it is unable to collect costs. Clearly, the DVHC admits that Act No. 94, by requiring the reinstatement of the 1971 Agreement, will not force a hospital to lose money on the Blue Cross portion of its business, but only prevent it from realizing a "profit".

84. Although the Williamson Affidavit repeatedly refers to free care losses it does not indicate that many of the DVHC represented hospitals have received substantial funds under what is commonly referred to as the Hill Burton Act. (42 USC § 291 *et seq.*) These sums are given as either outright grants or low cost loans by the Federal government to assist in hospital construction. As the *quid pro quo* for these taxpayer dollars, the hospital is required to provide "a reasonable volume of services to persons unable to pay therefor. . . ." (42 USC § 291c(e)(2)) In a recent decision involving this statute it was held "a recipient of Hill Burton funds is required by the statute to provide such services in such portion or portions of its facility as will constitute a reasonable volume in light of the needs of the community and the amount of the grant." *Corum* v. *Beth Israel Medical Center*, 359 F. Supp. 909, 917 (S.D.N.Y. 1973). Moreover, a recent HEW regulation (42 CFR § 53.111) requires that a hospital recipient of Hill Burton funds must regularly advertise this fact and solicit patients who are financially or medically indigent. A copy of this regulation and the accompanying discussion of this ruling which appeared in the Federal Register is attached as Exhibit 45. Clearly, having elected to utilize federal funds, it is difficult to understand why the hospital should now seek to collect from others the cost of rendering the free care which it is required by law to provide.

85. The two hospitals identified in the Affidavits of Clark ("Episcopal") and Anderson (Mercy Catholic Medical Center—"MCMC") were beneficiaries of Hill Burton funds. Episcopal received $1,581,200 in May 1964, and later in February 1971, an additional $400,000. MCMC was given $866,000 in May 1974 with an additional $954,000 provided as a 3% loan. Importantly it should be recognized that although these funds were provided from tax rev-

enues, the Plan reimburses these hospitals for the full "depreciation" attributable to the facilities built with these monies without any setoff for the government's contribution.

86. Although I am obviously not intimately familiar with the source of all major hospital capital contributions, the fact that the main building at Fitzgerald Mercy-MCMC was a gift is well chronicled. However, as with hospitals built utilizing government funds, the Plan, pursuant to the 1971 Agreement, allows full "depreciation" on the contributed structure notwithstanding the fact that such contributions are subsidized by the general public in the form of lost tax revenue.

87. Although the Guest and Williamson Affidavits argue that hospitals have substantial free care losses, I am not aware of any statute or regulation, other than the Hill Burton Act, which requires a hospital provide patient care without compensation. Indeed, both the Medicare and Medicaid programs are voluntary and a hospital may elect not to participate. Thus, if a hospital does in fact provide care for which it not fully paid, it must be in recognition of its charitable character and as a recognition of the substantial tax deductible contributions that it does receive.

88. Paragraph 8 of the Williamson Affidavit makes an interesting concession when he suggests "unrestricted endowment fund income can be applied to reduce the hospitals net operating loss". However, he asserts Episcopal, MCMC and Presbyterian are in such dire financial condition as to preclude this action, although a review of their financial statements accompanying the Clark, Anderson and Mosher Affidavits shows each hospital's assets increased during the reporting period. Further Mr. Lynch's Affidavit underscores certain questionable expenses which purportedly produced a net operating loss.

89. None of the affidavits filed on behalf of the Plaintiffs in this case specifically identify the source of their unreimbursed patient care losses. Rather, they point vaguely to free care services, bad debts and the like. For my part, I believe a goodly position of these purported "losses" may be traced to the effect of the 1971 Agreement in requiring all hospitals implement effective cost and quality control measures. As indicated in paragraph 80 above, depreciation and interest on capital projects and facilities which do not meet safety or need standards are no longer reimbursed. The costs attendant hospitalization, whether in whole or part, that is not medically appropriate will similarly not be reimbursed. (See Principle II, 1973 Agreement) Further, generic rather than brand name drugs are required except in isolated cases (Section 16), purchasing proceures must conform with the prudent buyer concept (Section 19), and strict budget controls must be followed (Section 18). In cases where these rules are not followed reimbursement is reduced or denied. When added to the losses hospitals incur in areas not involving the rendition of patient care, there seems little to substantiate any allegation of true losses attributable to patient care.

/s/ BRUCE TAYLOR

Bruce Taylor

Sworn to and subscribed
before me this day
of November, 1975.

Notary Public
My Commission Expires

AFFIDAVIT OF JEROME LYNCH
EXECUTIVE VICE PRESIDENT,
BLUE CROSS OF GREATER PHILADELPHIA

COMMONWEALTH OF PENNSYLVANIA }
COUNTY OF PHILADELPHIA } *ss:*

JEROME LYNCH, being duly sworn according to law, deposes and says that he is the Executive Vice-President of Blue Cross of Greater Philadelphia, one of the defendants named in the foregoing action; that as such he is duly authorized to, and does make this Affidavit on its behalf based on his personal knowledge, and that such statements are true and correct. Further, deponent says in reply to the Affidavits of Paul I. Guest, Chairman of the Delaware Valley Hospital Council and President of Methodist Hospital ("Guest Affidavit"), Joseph A. Williamson, President of the Delaware Valley Hospital Council ("Williamson Affidavit"), Fred G. Clark, Vice-President of Finance, Episcopal Hospital ("Clark Affidavit"), Ragnar W. Anderson, Acting Director of Fiscal Affairs and Controller of Mercy Catholic Medical Center ("MCMC"), Fitzgerald Mercy Division ("Anderson Affidavit"), and Carl L. Mosher, President of Presbyterian-University of Pennsylvania Medical Center ("Presbyterian") ("Mosher Affidavit"), that:

1. Paragraph 14 of the Guest Affidavit suggests that Jeanes Hospital will lose more than $50,000 in the current year. Yet, the most current financial statement of that hospital which was included as Exhibit 36 to the Taylor Affidavit indicates it earned $303,650 in 1973 and $284,945 in 1974. Further, if "depreciation", which amounted to more than a quarter of a millon dollars in each of these

years and is largely attributable to contributed property be added to this net, Jeanes Hospital has realized an annual profit of more than half a million dollars. In light of these facts, it is difficult to understand how the Hospital can now allege it will lose more than $50,000 in the current year.

2. The closing "argument" contained in the Guest Affidavit suggests that Jeanes Hospital is unique in having a "financially secure" position. This is unsupported by an analysis of the most recent financial statements of the other DVHC represented hospitals. For example, Taylor Hospital realized an operating profit each year from 1971 to 1975. When non-operating revenues are added, the net profit for that Hospital in 1974 was $750,066 and $291,719 in 1975. Interestingly, Taylor Hospital showed an increase of over $1.2 million in its unrestricted fund balance from 1974 to 1975, hardly the sign of a financially ill institution. A copy of the financial statement of Taylor Hospital, as of June 30, 1975, prepared by its certified public accountants, Maillie, McCarraher, Lennon & Co. is attached hereto as Exhibit A.

3. Lest it be thought Taylor Hospital is an isolated example of a DVHC represented hospital which has had a favorable operating experience, there are attached hereto copies of the most recently available operating statements of Sacred Heart Hospital-Norristown (Exhibit B), Doylestown Hospital (Exhibit C), Sacred Heart General Hospital (Exhibit D), Riddle Memorial Hospital (Exhibit E), Wills Eye Hospital (Exhibit F), Paoli Memorial Hospital (Exhibit G), and Delaware County Memorial Hospital (Exhibit H), all of which hospitals realized operating profits for the past two years. Of course, these hospitals also realized significant non-operating income which added significantly to their earnings per-

mitting large increases in net worth. Indeed, if all the financial statements of the DVHC represented hospitals were to be inspected, most, if not all would show yearly profits, even after allowance for "depreciation" and losses not connected with patient care.

4. Obviously, Mr. Williamson failed to consult the hospitals referred to above prior to the preparation of his Affidavit since he alleges in paragraph 5 that all hospitals suffer operating losses. Further, he ignores the fact that most of the DVHC represented hospitals, including two of three carefully selected ones referred to in his Affidavit, received significant Hill Burton funds for the construction of their facilities. As Mr. Taylor indicated in his Affidavit, the statutory and case law requires that hospitals taking such funds must provide certain amounts of free care.

5. Paragraph 4 of the Williamson Affidavit indicates that a "substantial portion" of a hospital's bad debt cost is attributable to treating inpatients who enter the hospital as Blue Cross Subscribers but whose coverage expires prior to their discharge. Since this allegation is not supported by any substantive evidence to the best of my knowledge it would be well to review the clearance procedure employed by the Plan. When a Subscriber is admitted, the hospital, by phone or telex, inquires of the Plan as to whether or not the individual is entitled to Blue Cross benefits. In its response, the Plan advises of the status of the individual and further, indicates the number of covered inpatient days to which he is entitled. Thereby, the hospital is placed on notice as to the amount of coverage for which the Plan is liable and may, at the expiration of the covered period charge the Subscriber the full retail rate or charges for any continuing stay. Thus, although there may be some bad debts incurred, such are properly

attributable to the hospital's poor administrative or collection procedures.

6. The Clark, Anderson and Mosher Affidavits contain various allegations as to the perilous financial conditions of the three identified hospitals and their relationship with the Plan. Although I will not respond to each and every allegation, certain factual inaccuracies or omissions are of sufficient significance to mandate a reply.

7. The Clark Affidavit suggests in paragraph 5 that Episcopal Hospital had a net operating loss for the fiscal year ended June 30, 1975 of $1,296,301. In support of this position, Mr. Clark attaches the financial statement prepared by its auditors, Coopers & Lybrand. However, what the Clark Affidavit does not say is that this loss is not a true operating loss for it reflects many expenses not associated directly with the hospital operation.

8. Included in the operating expenses incurred by Episcopal, shown on page 4 of its statement, are certain costs not attributable to patient care rendered at the Hospital. For example, based on costs reports submitted to the Plan, Episcopal expended during fiscal 1975 a total of $961,124 on its outpatient clinic, a supposedly government financed Model Cities program, $597,726 on emergency room services, $473,397 on the Harrison House, a retirement home, $844,933 for off-site mental health facilities, another government sponsored program, $156,000 on off-site rental units, and $31,586 for its coffee, thrift and gift shops. However, the revenues realized from governmental sources for the outpatient clinic and mental health facility amounted to no more than the $929,632 shown on the operating statement as the total governmental supplement to the Hospital, thereby creating a loss of at least $900,000. Further, the Harrison House, a home for Episcopalian retirees, produced a loss of $189,000 when costs

are netted against revenues as shown by the Hospital's own trial balances. Similar losses of somewhat smaller proportions also resulted from the other areas identified above and when aggregated exceed the claimed net operating loss. Further, if realized non-operating revenues of $661,000 be added, the institution showed a healthy profit for fiscal 1975.

9. Paragraph 7 of the Clark Affidavit suggests Episcopal was required to reduce its endowment fund principal by nearly $1 million during the period 1973-1975, but its financial statements for those periods indicate both its restricted and unrestricted funds increased as below:

Year	Restricted Funds	Unrestricted Funds
1973	$6,511,362	$7,919,956
1974	6,653,887	7,837,551
1975	6,700,800	8,044,753
TOTAL INCREASE—$324,235		

Further, an actual inspection of these financial statements show that at year end 1973 the endowment fund was costed at $6,060,004, while at the same date in 1975 it was $6,062,936. Importantly, this fund is carried per books at cost, while the balance sheet shows that the market value at June 30, 1975 of this fund was $8,346,330.

10. Although paragraphs 10, 11 and 12 of the Clark Affidavit suggest Episcopal has been forced to invade endowment fund principal to meet current operating expenses such is not fact. Whether money for operations be derived from "depreciation" or other sources is largely academic. The Hospital did indeed show gains in its restricted and unrestricted funds during the referenced periods and any operating loss is traceable to non-hospital related functions.

11. The Auditors' Report prepared by MCMC's certified public accountants, Haskins & Sells, upon which the Anderson Affidavit is based requires two observations. First, the Report is prefaced by a "qualified" opinion and, secondly, the Report is dated August 14, 1975 although it purports to cover a period fourteen months prior. Since it is the normal practice of accounting firms to submit audited statements within 90 days after the close of the period, this delay would suggest that the books and records of MCMC were either incomplete or required revision at the end of the indicated fiscal period.

12. The certified public accountants retained by the Plan to prepare the final audits required by the 1971 Agreement also had considerable difficulty in obtaining access to MCMC's books of account, invoices and other financial documents, as is shown by letters and status reports from Ernst & Ernst, copies of which are included as Exhibit I. A check of the status of all other hospital field audits conducted for the Plan indicates that MCMC is the only one still outstanding as of this writing.

13. Note 2 to the MCMC statement is also somewhat disturbing, since the Hospital has been required to write-off substantial accounts receivable which suggests some weakness in the financial accounting procedures of that institution as is well evidenced by the auditor's "qualified" opinion.

14. In paragraph 5 of the Anderson Affidavit, he indicates MCMC made provision for free care and uncollectible accounts amounting to $3,043,544. This figure, computed at charges which would necessarily include the hospital's markup, must incorporate some provision for write-offs of accounts receivable for prior years which were theretofor included as assets. Due to this treatment it cannot be said with any degree of certainty what the

true operating results of MCMC were for the indicated fiscal period.

15. The mark-up of charges over Blue Cross cost which is alleged in paragraph 7 of the Anderson Affidavit is difficult to confirm, although the Plan's calculation indicates the figure to be substantially less.

16. The allegation in paragraph 8 that MCMC experienced delay in the receipt of Blue Cross reimbursement averaging 42 days is most distressing. A special study of current billings conducted specifically to assess the correctness of this charge indicates the Plan remits, to all contracting hospitals, 96% of its billings within 14 days and 99% within 30 days of receipt. Interestingly, an analysis of MCMC's recent billings reveals several internal problems at that Hospital. The average time from the date a patient is discharged from MCMC to the billing date shown on its invoices submitted to the Plan averaged more than 14 days. Moreover, a 10-day delay was noted between the invoice date and the actual date the invoice was mailed. For its part, the Plan's turnaround time between receipt of invoices and disbursement of payment, exclusive of weekends, was approximately 5 days. Importantly, in order to develop the foregoing averages it was necessary to completely eliminate many invoices applicable to hospitalizations in early 1975 when the in-hospital delay incurred in preparing billings ran upwards of six months after the date of the patient's discharge.

17. Exhibit A to the 1973 Agreement contemplated that hospitals would complete and submit billings within 7 days after discharge and the Plan would process such within 6 days after receipt, plus an allowance of two days for mail deliveries to produce an anticipated delay of 15 days. The advance program referred to in paragraph 8

of the Anderson Affidavit, which is fully described in Exhibit A to the 1973 Agreement, was intended to provide working capital to cover this period. However, in cases where the delay is clearly due to administrative delays within the hospital the advance program cannot be faulted.

18. The Mosher Affidavit is based on the financial reports prepared by its certified public accountants, Coopers & Lybrand for the period ended June 30, 1974. Since the Plan had received the certified financial statement of Presbyterian under date of September 12, 1975 from Coopers & Lybrand for the fiscal period ended June 30, 1975, I would be at a loss to explain why the stale financial statement was used were it not for the fact that Presbyterian showed a remarkable turn-around in fiscal year 1975 which apparently Mr. Mosher feels would detract from his presentation. A copy of the 1975 statement is attached as Exhibit J.

19. In paragraph 5 of the Mosher Affidavit, it is alleged that Presbyterian provided free care amounting to an "unrecovered cost to the Hospital of $847,500". However, as this figure is based on charges that have been written off and therefore constitutes uncollected revenue, it is not a true bare bones cost, but rather includes a mark-up to retail. Therefore, the free care loss, if indeed it could be called that, is substantially less than the figure indicated.

20. Although Mr. Mosher indicates in paragraph 7 that Presbyterian showed a "bottom line net loss of $789,000 for fiscal 1974", this includes expenses attributable to nonreimbursable areas, such as research and a convalescent home maintained by the Hospital. Further, the loss is inflated by a charge of $184,933 arising from fund

raising functions which undoubtedly added "restricted" funds which have not been included in the income statement. The fact that these non-patient care related costs are substantial and the Hospital itself has not been financially injured, is well demonstrated by the fact that Presbyterian realized a year-to-year increase in all its fund balances, both restricted and unrestricted, for the instant reporting period over that of the prior year.

21. Mr. Mosher states in Paragraph 9(a) that the Plan improperly withheld certain reimbursement which was properly due and payable. This certainly is not the case. During 1970, the Plan challenged the costs of Presbyterian as being out-of-line with those of comparable hospitals in accordance with Principle 2-1 to Exhibit A of the 1967 Agreement. The final settlement of $330,000 represented a compromise achieved through negotiations between the Plan and Hospital which tacitly recognized the validity of the Plan's position. Further, Section 15 of the 1967 Agreement specifically provided for appeals through an arbitration and ultimately the courts in the event the contracting parties were unable to amicably resolve their differences. The fact that Presbyterian failed to pursue this remedy is not to be overlooked.

22. Paragraph 9(b) of the Mosher Affidavit suggests that the Plan has been delinquent in not settling its account with Presbyterian for the fiscal year ended June 30, 1975. This is not so. The Hospital's cost report was received by the Plan on September 24, 1975. Thereafter, on October 8, 1975, Presbyterian notified the Plan of a material error in its report and on October 17, 1975 the revised schedule correcting the errors in the original report was received. A copy of the Memorandum and letter from John Kohler, Presbyterian's Cost Manager advising of these discrepancies is attached as Exhibit K hereto.

23. Mr. Mosher alleges in Paragraph 9(c) of his affidavit that the Plan has failed to revise and adjust Presbyterian's interim per diem reimbursement rates in accordance with the Hospital's fiscal 1976 operating budget. What he fails to add is that the budget of September 10, 1975, required additional information, and such was submitted by letter dated October 6, 1975, a copy of which is attached as Exhibit L. Since Section 18 of the 1971 Hospital Agreement affords the Plan a 45 day period in which to review operating budgets and adjust interim rates, the time frame within which such action should take place has not yet expired. However, if the Plan fails to act within this period, Section 18 further provides the hospital's budgeted rate will then become effective.

/s/ JEROME LYNCH
Jerome Lynch

(Oath and Jurat Omitted in Printing)

Opinion and Order of February 27, 1976 (appended to Jurisdictional Statement)